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ABSTRACT

A report is presented on a special review seminar for Vietnamese physicians preparing for the July 1976 Educational Council for Foreign Medical Graduates (ECFMG) examination. The 4-month review course was offered to 73 physicians at Hahnemann Medical College & Hospital. Participants were assigned to 10 small sections for English classes, and groups of four were assigned to individual tutors for concurrent remedial work in medicine and an introduction to the local practice of medicine. The medical course presented an integrated approach to basic and clinical sciences. The 20 students who passed the medical component but failed the English part of the ECFMG examination were advised to attend the FLEX review course. Special videotaped lectures were made available to the students, as was a cultural orientation course. Lengthy appendices include: a course application form; student financial statement form; the English course schedule and information on teaching materials and learning activities; language evaluations of the participants; ECTFMG review course schedule; test scores; instructional materials on diseases; results of participants' evaluation of the course; a list of faculty and staff; staff evaluations of the course; a list of course objectives; and case studies. (SW)

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HRP-0903990

PROJECT REPORT

INDO-CHINESE REFUGEE PHYSICIAN

ECFMG REVIEW COURSE

HAHNEMANN MEDICAL COLLEGE & HOSPITAL

ED225425

HE 015 735

U.S. DEPARTMENT OF EDUCATION
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PROJECT REPORT

RECRUITMENT: Letters requesting enrollment (see attachment A-1) were sent out to all students who were assigned to our program by HEW. Some of the students failed to reply. Mr. Nguyen Van Quy (who was later assigned the task of liasion officer) was able to contact all the individuals via telephone and give them complete instructions about registration, arrival and reporting, as well as other pertinent information. This was necessary since we discovered the majority of the refugee physicians were unable to communicate in English with our regular Social Work Service Staff. Total number of physicians registered was seventy-five (see attachment A-2). Two of the students registered and did not show up. The five students who did not register for the course were sent letters by Mr. Simmons and the reasons for not arriving were requested (see attachment A-3 for response and details).

Arrangements for placing the students with American families fell through because of circumstances beyond the control of our Director of Social Work Services. All the students were initially placed at the YMCA and YWCA and the presence of personnel from our Social Work Service Department at the YMCA and YWCA insured proper reception and orientation of the students. The vast majority of the students arrived with meager funds, and Hahnemann undertook guarantee of board and room at the YMCA and YWCA, and provided the students with meal tickets to be used at the Hahnemann Cafeteria. Some students were in dire need and were advanced money till the stipends from HEW were available

Over a period of one month the majority of the students were placed either at the Hahnemann Student Towers or in apartments. The Social Work Service personnel were very active in locating apartments and in providing transportation and escorting the students for the move to apartments from the YMCA and YWCA. Some of the students voluntarily decided to stay at the Y's for their own convenience, since the YMCA is only two blocks from Hahnemann

Assessment of financial need was made using the college entrance examination boards student financial need forms. The analysis of the form was made by John Simmons, Director Social Work Services and Douglas Geary, Executive Director, Department of Medicine. All the students were found to qualify for the stipend and stipends were paid at the rate of $250.00/month for four months.

Assigned social workers had primary responsibility for maintaining continued contact with the students, providing personal counseling and emotional support in relocation problems, adjustment to the review course, and medical needs, as well as to make the students aware of the various types of services available to patients, the many professions and facilities involved in the delivery of health care in the United States. This was to be achieved through individual and group presentations, field trips, etc.

The students made active use of the Social Work Services resources made available to them, especially for personal medical needs, dental care, opthalmologic care. The students were at times annoyed that major dental work of a nonemergency nature was not available to them as soon as it was requested.

The students had scheduled group meetings with their social workers but after the first five weeks expressed a desire to do away with these sessions since the easy access they had to the social workers made formal meetings unnecessary (in the students opinion). The scheduled meetings were eliminated.

There were no overt major medical or psychiatric problems among the students. It is probable that this stemmed in part from the excellent support the students received from the Social Work Service Personnel. Social Work Service Staff (see attachment A-4)

General administrative aspects

The students were randomly assigned to ten small sections for English classes. Each section elected a representative. The project director held weekly conferences with the representatives to obtain student input into the course and to keep the project director advised of current and potential problems pertaining to the students physical, medical and educational needs.

The students were also assigned to the Social Work Service Service personnel on a random basis. The groups assigned to a Social Worker were different from the small English sections. This appeared to annoy some of the students but we felt there was significant benefit in cross-fertilization concerning support and solution to problems encountered by the students (see attachment B-1)

The students were requested to form groups of four (of their own choice). These study affinity groups were assigned to individual tutors for concurrent remedial work in medicine and an introduction to the local practice of medicine. (see attachment B-2). When the results of the ECFMG Examination held on January 23, 1976 became available to us the students who had passed the medical component were permitted to participate in the FLEX Course that was being offered at Hahnemann and the tutorial groups were reassigned. (see attachment B-3).

On 2/2/76 the students were oriented to the course and facilities, as well as their group assignments, and a pretest in English Language skills was administered using a battery of tests (see attachment C-3).

We had a discussion group made up of English faculty, social work service staff, student representatives, and cultural orientation course faculty, to orient the cultural orientation course faculty to the abilities, interests, problems and learning difficulties that are likely to be encountered. This appeared necessary in view of the fact that this is the first cultural orientation course offered at Hahnemann for foreign medical graduates. The medical faculty needs minimal orientation because they have already been involved in training foreign medical graduates and are fairly conversant of the problems encountered by students training in medicine under the European system and of Asian origin. The student representatives in turn were oriented to the content and need for the cultural orientation segment of the program.

The students were introduced to their medicine tutorial preceptors at a social evening and established a means of communication with their preceptors to facilitate the scheduling and content control of the tutorials

ENGLISH COURSE

Schedules and teaching materials (see attachments C-1)
Faculty (see attachment C-2)

The Basic English classes were presented to larger groups. The evening and Saturday classes were run in small groups of 8 to 10 students, and the teaching techniques employed by the various instructors were discussed at weekly staff meetings conducted by the project director to insure cross fertilization, evaluation of student motivation and participation as well as progress over time.

At the completion of the first week 30 of the students were exempted from the basic English lesson based upon their performance in the tests and recommendations of their evening English Language usage teachers. These exempted students were placed in regular medical lectures presented to the Hahnemann medical students and gave us an insight into the pro lems they are likely to encounter during the Medical Lectures. The major problem appears to be their diffidence in interrupting the lecturer when material was incomprehensible and the monor problem was their dependence on notes. These students were also allowed to view the video-taped medical lectures and it appears that their ability to register material at the pace that it was presented on the video-tapes had improved remarkably towards the end of the third week (as per their own admissions.) Our medicine tutorial program was implemented earlier than anticipated in order that the students obtain access to teachers who can answer questions that they did not ask during the lecture. Four students were assigned per preceptor for remedial work two to three hours per week depending upon student's need. The material for review was identified by the students based on the learning problems encountered during the week's lecture presentations, and supplemented by weakness identified by the examinations. An ancillary benefit of this tutorial program was exposure of the students to patient's problems, various laboratory tests and medical practice in teaching hospitals. The assignment of the students to various groups was determined by the students themselves.

The English faculty was greatly impressed by the enthusiasm and effort demonstrated by the students despite a 7-hour per day class schedule. We found very little resistance on the part of the students to this high pressure, concentrated English teaching. We believe that the students who were exempted from the Basic English and were allowed to attend the medical lectures were influential in convincing the entire group of the importance of improving listening comprehension and verbal communication skills.

Material for improving aural comprehension were prepared and used to improve both aural comprehension and structure as well as to increase vocabulary.

Improvement of the students English language skills and progress over time was evaluated by student profiles by the English teachers. (see attachment C-2) and by frequent objective tests using multiple established instruments (see attachment C-3 for lists of tests.)

We were pleasantly surprised by the performance of the students in the above mentioned tests. It appeared that their problem in English was more in the structure and listening comprehension areas. (see attachment C-4 5 for student performance on the tests).

There was remarkable improvement in the students' English language skills. This was very evident in the medical lectures and review sessions, as well as class meetings where the students demonstrated an increasing ability to verbalize in English. Skills were also assessed by the medicine tutors. (see attachment D-3).

For the students who passed the medical component, failed the English component of the ECFMG Examination, a separate English Course was presented from March 20 until May 30. The course schedule was 3 p.m. - 6 p.m. daily.

The students required to take the TOEFL were informed of the special test that was scheduled by TOEFL for 4/3/76. Fee voucher cards were arranged for these students. This enabled them to take the test without having to pay the examination fee. Mr. Schaeffer insured that all the students who wished to do so were registered for the test. Those students who had withdrawn from the course were also informed and registered for the test. We plan to carry the names of the physicians taking the E.C.F.M.G. Examination in July 1976 on our rolls as special students, and follow up with assistance with registration and fee voucher cards for those students who might be required to retake the English Component of the ECFMG.

Total hours for English Course .460 .

MEDICAL COURSE

This was designed to present an integrated approach to basic and clinical sciences as far as possible. In some areas it became necessary to make presentations in pure basic medical sciences. An Attempt was made to place emphasis on the different clinical disciplines in such a manner as to reflect the weight of these disciplines in the E.C.F.M.G. Examination. The speakers were aware of the language difficulties the students encountered and made the necessary effort to insure comprehension. Regular review sessions were held for the entire class wherein the more important aspects of the weeks' presentations were discussed. The major portion of the review classes was presented by the project director and other members of the faculty who had themselves taken the E.C.F.M.G. Examination, additionally during these sessions.

All the questions reaised by the students were addressed. The questions the students raised increased in number toward the end of the course.

Early in the Course the students had expressed a desire to have the course terminate on 5/31/76, but towards the latter part of April, 1976, the majority of the students requested additional review sessions extending up to June 9, 1976, and the course was formally terminated on June 9, 1976.

Examinations were given regularly before and after presenting a segment of the course and since the same examinations were used as pre and post tests, and the examination books were only given to the students after the post test, we had a reasonable measure of the increase in the students knowledge. The faculty was not aware of the examination questions and therefore did not teach to the examination which assured the project director that improved performance by the students did indeed represent gain in knowledge. Some of the examinations were reviewed with the students and the question phraseology, as well as examination taking were discussed.

The 20 students who had passed the medical component but failed the English component of the ECFMG Examination held in January 1976 were advised to attend the FLEX review course. This course not only would improve their medical knowledge but also their English language skills because the other students in the FLEX Course were quite proficient in English and, in communicating with them, the Indo-Chinese Physicians would per force have to use English.

Some of these physicians withdrew from the course because of personal, financial or job situations. (see attachment D-1, list of these students and the dates on which they withdrew from the course.

Course time 441 hours (see attachment D-2)
Conferences 14 hours
Tutorial hours 217 (see attachment D-3)
Medical Faculty - (see attachment D-4)
Tutorial Faculty - (see attachment D-5)
Evaluation:
1. Multiple choice questions mostly of the type used in the ECFMG. Total number of items used (see attachment D- for student profiles.) 1,800
2. Assessement of medical, problems solving communication skills, effort and interest of the students by the physician's tutors (see attachment D-7)

Use of ancilliary teaching aids. - Special video-taped lectures were made available to the students and a viewing facility of two video monitors carrels was set up for the exclusive use in the Indo-Chinese physicians. Each videotape has a set of behavioral objectives which were distributed to the students. (See attachment D-8) The students after viewing the video tapes requested that they be given answers to the objectives. There were specially prepared and distributed.

The students had the usual library privileges and used them extensively, including books, slide tapes and audio-tapes.

CULTURAL ORIENTATION COURSE

FACULTY - (see attachment E-1)
COURSE OUTLINE (see attachment E-2)

This was delivered on Fridays from 9 a.m. to 12 noon. The Course Director personally attended and supervised every session to improve personal contact and to maintain continuity of discussions where necessary. On the first day of the course a questionnaire was completed by the students which attempted to assess the student's expectations from this course, their immediate problems and their awareness of future work settings (see attachment E-3 for a detailed analysis of the results of the questionnaire). The Students attendence of this course fluctuated and tended to drop off towards the end of the course. Since student motivation was of paramount importance in benefiting from this course, although students were encouraged to attend they were not forced to do so. During the course disscussions of the insecurity that the student felt, the distrust that they apparently had of their environment was expressed freely. A significant presentation of one session was devoted to questions by the students of the possibility that they might be exploited professionally and discriminated against. Nine hours of the course were presented by our Psychiatric medical staff who expressed concern about the emotional well-being of the students (see attachment E-4 for complete report by Drs. Bradley Seven and Michael Vergare). Since the Psychiatrists' involvement with the students was towards the end of the course, and with the student who had perservered in attending the course. This impression of the students' was disturbing.

It became apparent during this as during other segments of the course that the students were most comfortable in an educational setting where they dealt with concrete situations. Their ability to conceptualize, to solve problems using information that they had, but in an unfamiliar setting was very limited. Their interpersonal skills appear to be limited possibly because of lack of training or because of a prior concept that the students had the physicians relative infalability and authority.

This course, to a certain extent, succeeded in encouraging the students to verbalize, to overcome their inhibitions of being critical and to accept criticism with a more appropriate response. At the completion of this course the students undertook a written evaluation (see attachment E-5 for the course directors analysis of the evaluation.

Mr. Eugene Grace from the ECFMG sat in on three of the sessions in order that he may obtain information and another point of view that would help him in his endeavor of establishing guidelines for Cultural Orientation to be used by residency training programs having foreign medical graduates amongst the residents

Course outline (see attachment E-6)

OTHER ASPECTS

Those students who passed the ECFMG examination as well as those who withdrew from the course were familiarized with the process of applying for residency positions, and the interview process. The importance of communication skills in the interview was reiterated on numerous occasions. The rest of the students were familiarized with the above procedures towards the end of the course.

Mr. Schaeffer personally presented the list of candidates to the ECFMG and confirmed that the credentials of all our cnadidates were in order and in one instance (Dr. Vu Hoat) there was an error on the part of the ECFMG who claimed that Dr. Hoat had not submitted an application. This was investigated and the ECFMG managed to locate Dr. Hoat's application.

The students were informed of a funded special program for Indo-Chinese refugee physicians that was being presented by the University of New Mexico. They were advised to contact Dr. Kenneth Dr. Gardiner, Assistant Dean for Graduate Medical Education, School of Medicine, University of New Mexico, Albuquerque, New Mexico, 87191.

The Department of Medicine - Hahnemann Medical College is exploring the possibility of initiating a one year post graduate training program for Indo-Chinese refugee physicians. If funding can be obtained from the state the program will enroll eight physicians and I am optimistic that the program will be funded.

Dr. Vu Gia An and Dr. Vu Hoat were of great service to the group and the course. They have leadership potential and should be helpful in future undertakings.

ATTACHMENT A-1

THE HAHNEMANN MEDICAL COLLEGE & HOSPITAL OF PHILADELPHIA
TWO-THIRTY NORTH BROAD STREET PHILADELPHIA, PENNSYLVANIA 19102

CONTINUING EDUCATION

Thank you for your letter concerning the special review seminar for Vietnamese and Cambodian physicians in preparation for the July 21, 1976, ECFMG examination. The program at Hahnemann Medical College will begin Monday, February 2, 1976, and continue through June 11, 1976. Classes will be held Monday through Friday from 8:00 a.m. to 4:00 p.m., and on Saturday, from 9:00 a.m. to 1:00 p.m.

To facilitate the registration process, we ask that you complete the attached forms and return them to: DIVISION OF CONTINUING EDUCATION, HAHNEMANN MEDICAL COLLEGE & HOSPITAL, 230 NORTH BROAD STREET, PHILADELPHIA, PENNSYLVANIA 19102. All forms should be received by this office no later than January 23, 1976.

To qualify for this seminar you must be eligible to sit for the July 21, 1976 ECFMG Examination. If you have not registered for the July 21 ECFMG Examination, it is suggested you do so as soon as possible. The ECFMG deadline for registration is April 21, 1976. If you need assistance in completing this material, we will provide aid upon your registration.

There are no housing facilities available on the Hahnemann campus. If you require living accommodations, please complete the attached housing form and our Social Work Department will provide assistance.

The course is tuition-free. If you need financial assistance to cover your living expenses during your period of study, please complete the financial statement form attached and return it with the other material by January 23, 1976. If you are eligible for financial aid, you will receive: 1) stipend support of not more than $250.00 per month, not to exceed a total of $1,000.00 for the duration of the program; and, 2) travel reimbursement for one round-trip fare from your home address to the course site. Receipts must be presented at the time of registration. There is no additional stipend nor travel support available under this program for the spouse, children or other family members of the eligible candidate.

- continued -

If we can provide additional assistance, please contact this office at (215)-448-8263. If any additional information becomes available to us prior to the start of the program, we will be in touch with you.

We are pleased that you will be participating in this program and look forward to having you with us at Hahnemann Medical College.

Sincerely,

Krishan Bharadwaja, M. D.
Assistant Professor of Medicine
Director, Division of Continuing
Education

KB/lmc
attachments

THE HAHNEMANN MEDICAL COLLEGE & HOSPITAL OF PHILADELPHIA
TWO-THIRTY NORTH BROAD STREET PHILADELPHIA, PENNSYLVANIA 19102

CONTINUING EDUCATION

NAME ______________________________
(First) (Middle) (Last)

ADDRESS ______________________________

CITY ______________ STATE ______________ ZIP __________

TELEPHONE __________ - __________
(Area Code)

PLACE OF BIRTH ______________ DATE OF BIRTH __________

AGE ______ SEX __________ MARITAL STATUS __________

CITIZENSHIP ______________________________

MIGRATION STATUS ______________________________

DATE OF ENTRY INTO THE UNITED STATES ______________________________
(Month) (Day) (Year)

REFUGEE NUMBER ______________

NAME OF SPOUSE ______________________________
(First) (Middle) (Last)

ADDRESS ______________________________

CITY ______________ STATE ______________ ZIP __________

NATIVE TONGUE ______________ OTHER LANGUAGES SPOKEN __________

MEDICAL EDUCATION ______________ ______________
(Medical School) (Location)

FROM ______________ TO ______________
(Month) (Day) (Year) (Month) (Day) (Year)

DEGREE OF DOCTOR OF MEDICINE WAS RECEIVED FROM ______________

ON ______________ 19______

PROFESSIONAL EXPERIENCE: Private Practice, hospital appointments, in countries outside the United States (please indicate your speciality).

____

____

____

List medical positions held in the United States or with United States organizations

____

____

____

Faculty Appointments (indicate school, university, position and dates)

____

____

____

____

Publications __________________________________

____

Medical Society memberships __________________________

____

____

ECFMG NUMBER ________________________

Have you taken the ECFMG Examination? _____ Yes _____ No

Are you registered for the July 21, 1976 Examination _____ Yes _____ No

Please indicate where you are scheduled to take the July 21, 1976 ECFMG Examination ____________________________

____
Signature of Applicant

Please attach copies of Medical Diploma and four 2x2 photographs and mail to:

DIVISION OF CONTINUING EDUCATION
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL
230 NORTH BROAD STREET
PHILADELPHIA, PENNSYLVANIA 19102

ACCOMMODATION FORM - SOCIAL WORK SERVICES

NAME ____
(First) (Middle) (Last)

AGE: ____________________

ENGLISH LANGUAGE ABILITY:

_____ Excellent

_____ Good

_____ Fair

_____ Poor

ACCOMMODATIONS PREFERRED:

_____ Single Room - No Cooking

_____ Single Room - With Cooking

_____ Live with a Family

_____ Live with other Vietnamese Doctors

DO YOU HAVE YOUR OWN CAR?

_____ Yes

_____ No

SPECIAL NEEDS (Please list):

____

____

____

____

____

____

____

ATTACHMENT A-3

Physicians who did not register

1. Thai Quoc Cuong
   1301 Fourwie Street
   Michigan 48640

   Replied to Mr. Simmons but declined the offer since he was working at the Midland Hospital and was afraid he would lose his job.

2. Ngo Bich Van
   345 E. 86th Street Apt. 2G
   New York, NY 10028

   Replied, declined offer as he was registerd for a review course at the French and Polyclinic Hospital, New York, where a course sponsored by the American Council for Emigres in the professions. This course is presented in the evenings and allows the participants to continue to work.

3. Can Buu
   c/o Mr. Ky Tron Ha
   631 Carlton Avenue
   Brooklyn, NY 11238

   Responded and declined for essentially the same reasons as Dr. Ngo Vich Van.

4. Than Q. Ky
   631 Carlton Avenue
   Brooklyn, NY 11238

   Failed to reply to Mr. Simmons letter, but we learned that Dr. Ky was also enrolled at the French and Poly clinic review course.

5. Le Thi Phuong Thuy
   3660 Kenny Road
   Columbus, Ohio 43220
   Phone 614-262-8559

   Did not reply to Mr. Simmons letters nor did he respond to a phone message.

SFS

COLLEGE SCHOLARSHIP SERVICE
OF THE COLLEGE ENTRANCE EXAMINATION BOARD

CSS

Student's Financial Statement

Academic Year 1975-76

The Student's Financial Statement (SFS) may be filled out by any student who is requesting financial aid for the academic year 1975-76. The SFS assists post-high-school institutions and scholarship programs in evaluating your need for financial aid. Information from your parents may also be required.

Mail your completed SFS to the College Scholarship Service (CSS) address below at least one month before the earliest financial aid deadline required by the institutions and programs you list to receive the SFS. In addition to the information on this page, specific instructions for completing the SFS appear on the back page. Do not submit this SFS to the CSS after February 1, 1976.

General Information

College Scholarship Service. The CSS, an activity of the College Entrance Examination Board, reviews the SFS and sends a copy and an analysis to the institutions and programs you list. The information you provide on the SFS is confidential and is sent only to the recipients you specifically list.

The CSS does not award financial aid; rather, it evaluates your financial ability, and that of your family when appropriate, to contribute to the costs of your post-high-school education.

The decision to award financial aid rests with the individual institutions and programs, some of which may also request completion of a separate financial aid application.

Completeness of the SFS. In the interest of equity and fairness, it is important that you provide accurate and complete information on the SFS. Failure to do so may jeopardize your request for financial aid. *Your SFS will be returned to you if you have not listed the institutions and programs to receive this form,* or *if you have not completed the estimated 1975-76 resource items,* or *if you have not included the appropriate signatures.* Also, some institutions may require signatures in the Parents' Certification and Authorization section in order to verify your self-supporting status.

The CSS may request a copy of your (or your parents') U.S. Individual Income Tax Return in order to verify the information reported. Some institutions and programs may also request that you send a copy of your (or your parents') income tax return directly to them. *Do not send any income tax returns to the CSS unless specifically requested to do so.*

Special Family Circumstances. When parents' information is required and your parents are separated or divorced, the Parents' Information section of the SFS should be completed by the parent (and parent's present spouse, if any) who has custody of you. If someone other than the parent(s) provides the information, he should indicate his relationship to you and specify whose financial information is being reported in the Parents' Information section.

Fee. Enclose with your SFS $3.75 for the first institution or program you list and $2.25 for each additional one. Please make your check or money order payable to CSS. *Do not send cash. Any SFS received without the proper fee will be returned to you.*

Change in Family Circumstances. If your family circumstances change after your SFS has been submitted, contact the institutions and programs you list to receive the SFS. *Do not notify the CSS.* Be sure to indicate that you have filed the 1975-76 SFS and wish to report a change.

In correspondence with the CSS and on any separate sheets of paper that you may enclose with the SFS, be sure to provide the following *student* information: full name, date of birth, social security number, permanent mailing address, and the names of the institutions and programs to receive the SFS.

Additional Copies of the SFS. The SFS you submit is not retained by the CSS. Therefore, if you later wish to have an SFS sent to institutions or programs other than those you originally list, you must fully complete another SFS and submit it with the proper fee.

Special Note. For purposes of responding to items 7, 8, 9, and 10, the word "parent(s)" refers to your mother or father or any person (except your spouse) who provides, or did provide, more than one-half of your support.

IF YOU ANSWER YES FOR ANY OF THE YEARS IN ITEMS 7, 8, OR 9, THE PARENTS' INFORMATION SECTION OF THE SFS MUST BE COMPLETED.

OR IF YOU ANSWER NO FOR ALL YEARS IN ITEMS 7, 8, AND 9, OR IF BOTH YOUR PARENTS ARE DECEASED, THE PARENTS' INFORMATION SECTION OF THE SFS NEED NOT BE COMPLETED.

AFTER YOU COMPLETE THE SFS, FOLD IT SO THE FINANCIAL INFORMATION IS FACING OUT AND SEND THE FORM AND THE FEE TO:

College Scholarship Service
Box 300
Berkeley, California 94701

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Read instruc[illegible] [illegible]fore completing this form.
Do not send to CSS after February 1, 1976.

2 ☐ $6.00 4 ☐ $10.50 6 ☐ $15.00

STUDENT'S INFORMATION

1. STUDENT'S NAME

LAST NAME ▲	FIRST NAME ▲	MID INIT	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
			1 ☐ M 2 ☐ F	MONTH DAY YEAR	

2. STUDENT'S PERMANENT MAILING ADDRESS

NUMBER, STREET, AND APARTMENT NUMBER

CITY STATE ZIP CODE

3. Is student a U.S. citizen? YES ☐ NO ☐
If no, what is student's visa status?

4. Student normally lives:
☐ alone ☐ with parent(s)
☐ with husband or wife (spouse) ☐ with roommate(s)
☐ with relative(s)

5. Student's year in college or post-high-school institution during 1975-76: (Check only one box.)
FIRST (freshman) ☐ 1 SECOND (sophomore) ☐ 2 THIRD (junior) ☐ 3 FOURTH OR FIFTH (undergraduate) ☐ 4 GRADUATE PROFESSIONAL ☐ 5
Year in Grad./Prof. School ______

6. Name of institution student attended in 1974-75:

Student must answer each of the following questions for each year.

7. Did or will student live with parents for more than two consecutive weeks during

1974?	1975?	1976?
Yes ☐ 1	Yes ☐ 1	Yes ☐ 1
No ☐ 2	No ☐ 2	No ☐ 2

8. Was (or will) student (be) listed as an exemption on parents' U.S. income tax return for

1974?	1975?	1976?
Yes ☐ 1	Yes ☐ 1	Yes ☐ 1
No ☐ 2	No ☐ 2	No ☐ 2

9. Did or will student receive $600 or more of financial assistance from parents during

1974?	1975?	1976?
Yes ☐ 1	Yes ☐ 1	Yes ☐ 1
No ☐ 2	No ☐ 2	No ☐ 2

10. Are both parents deceased?
No ☐ 1
Yes ☐ 2

11. Student's marital status (check only one box):
1 ☐ Single
2 ☐ Married
Date of marriage: ______
3 ☐ Separated, Divorced, Widowed

12. How many children will be dependent on student for support during 1975-76? ☐

13. How many "other dependents" will be dependent on student for support during 1975-76? (Do not include spouse or anyone entered in 12.) ☐

14. How many of the children entered in 12 will be attending a tuition-charging elementary or secondary school during 1975-76? ☐

15. Enter below name and age of anyone entered in 12 and 13.

NAME	AGE	NAME	AGE	NAME	AGE	NAME	AGE	NAME	AGE

16. Spouse's name:

Spouse's occupation:

17. If spouse will be a student during 1975-76, check year in college or post-high-school institution. (Check only one box.)
FIRST (freshman) ☐ SECOND (sophomore) ☐ THIRD (junior) ☐ FOURTH OR FIFTH (undergraduate) ☐ GRADUATE PROFESSIONAL ☐
Year in Grad. Prof. School ______

18. Institution spouse will attend during 1975-76:
Check if financial aid applicant. ☐

[illegible] Do NOT [illegible] Use (71) for additional listings.

NAME	CITY	STATE	CSS USE ONLY	NAME	CITY	STATE	CSS USE ONLY

20. Check only one box. **Student's and spouse's expenses and resources below are for:** → → → 1 ☐ **nine months** 2 ☐ **twelve months**

[illegible]

Enter information in boxes only. Do not enter monthly amounts.	1974-75	ESTIMATED 1975-76
21. Student's tuition, fees, books, and supplies (See instructions.) →	$	$
22. Spouse's tuition, fees, books, and supplies →	$	$
23. Rent, mortgage, or room, including utilities →	$	$
24. Food or board and household supplies →	$	$
25. Clothing, laundry, and cleaning →	$	$
(26) Transportation (Itemize in (71).) →	$	$
(27) Medical and dental (Itemize in (71).) →	$	$
(28) Other expenses (Itemize in (71).) →	$	$
29. TOTAL EXPENSES →	$	$

STUDENT'S AND SPOUSE'S RESOURCES

Enter information in boxes only. Do not enter monthly amounts.	1974-75	ESTIMATED 1975-76
30. Financial assistance from student's parents →	$	$
31. Financial assistance from spouse's parents →	$	$
32. Student's wages, salaries, tips, etc. (before taxes and deductions) →	$	$
33. Spouse's wages, salaries, tips, etc. (before taxes and deductions) →	$	$
(34) Other taxable income (Itemize in (71).) →	$	$
35. Social security educational benefits →	$	$
36. Veterans—GI Bill educational benefits →	$	$
(37) Other nontaxable income and benefits (social security, child support, etc.) (Itemize in (71).) →	$	$
(38) Grants, scholarships, educational loans, and college work-study (Itemize, give source and dollar amount in (71).) →	$	
39. TOTAL RESOURCES →	$	$

[illegible] AND SPOUSE'S ASSETS AND INDEBTEDNESS

Enter information in boxes only.	ESTIMATE OF PRESENT MARKET VALUE	UNPAID MORTGAGE PRINCIPAL
40. Home if owned or being purchased → YEAR PURCHASED 19____ PURCHASE PRICE $______	$	$
(41) Other real estate (Describe in (71).) →	$	$
42. Cash, savings, and checking accounts →		$
(43) Other investments (present market value) (Itemize and give dollar amounts in (71).) →		$

Enter information in boxes only.	
(44) Business or farm, if owned (Complete A, B, and C below). (Describe in (71).)	
A. Total assets of business or farm →	$
B. Total indebtedness of business or farm →	$
C. Percent of ownership of business or farm →	%
(45) Debt outstanding (See instructions. Itemize and give dollar amounts in (71).) →	$

46. Name	Age	49. Name	Age
47. Home address		50. Home address	
48. Occupation	Title	51. Occupation	Title

52. **Student's Parents** *Check if living:* 1 ☐ Father 2 ☐ Mother 3 ☐ Stepfather 4 ☐ Stepmother

Check any that apply: 5 ☐ Parents Separated 6 ☐ Parents Divorced 7 ☐ Student has legal guardian (other than parents or spouse) 8 ☐ Father unable to work

If other unusual family circumstances exist, explain in (71)

53. How many dependent children did or will you claim as U.S. income tax exemptions (Do not leave blank.) for 1974? ☐	(54) How many children (list all by name in (71)), including the student, will be dependent upon you for support (Do not leave blank.) for 1975? ☐	55. How many children entered in 54 will be attending a college or post-high-school institution (Do not leave blank.) during 1975-76? ☐	(56) How many other dependents did or will you claim as U.S. income tax exemptions (Do not include anyone entered in 46, 49, 53, 54, or 55. Explain entries of one or more in (71). Do not leave blank.) for 1974? ☐ for 1975? ☐	57. How many of the children entered in 54 will be attending a tuition-charging elementary or secondary school (Do not leave blank. List by name and give dollar amount of tuition in (71).) during 1975-76? ☐

PARENTS' ANNUAL INCOME AND EXPENSES

Enter annual amounts in boxes only.	1974	ESTIMATED 1975
(58) Taxable income before deductions A. Wages, salaries, tips, and other compensation Father, stepfather, or male guardian →	$	$
Mother, stepmother, or female guardian →	$	$
B. Net profit from business or farm →	$	$
C. Other taxable income (dividends, interest, pensions, alimony received, etc.) →	$	$
(59) Nontaxable income (social security, veterans benefits, welfare, child support, etc.) →	$	$
(60) Employee business expenses (Itemize and give dollar amounts in (71).) →	$	$
(61) Medical and dental expenses not covered by insurance, plus medical insurance premiums (Itemize and give dollar amounts in (71).) →	$	$
(62) Emergency expenses (See instructions. Itemize and give dollar amounts in (71).) →	$	$
63. U.S. income tax paid (See Instructions. Do not include any tax overpaid.) →	$	
64. State income tax paid (See Instructions. Do not include any tax overpaid.) →	$	

PARENTS' ASSETS AND INDEBTEDNESS

Enter information in boxes only.	ESTIMATE OF PRESENT MARKET VALUE	UNPAID MORTGAGE PRINCIPAL
65. Home if owned or being purchased → YEAR PURCHASED 19 ____ PURCHASE PRICE $ ____	$	$
(66) Other real estate (Describe in (71).) →	$	$
67. Cash, savings, and checking accounts →		$
(68) Other investments (present market value) (Itemize and give dollar amounts in (71).) →		$
(69) Business or farm, if owned (Complete A, B, and C below.) (Describe in (71).) A. Total assets of business or farm →		$
B. Total indebtedness of business or farm →		$
C. Percent of ownership of business or farm →		$ %
(70) Debt outstanding (See instructions. Itemize, state purpose, and give dollar amounts in (71).) →	$	

(71) **Use this space to explain all circled items and any unusual circumstances.**

STUDENT'S AND SPOUSE'S CERTIFICATION AND AUTHORIZATION

I (We) declare that the information reported is true, correct, and complete. I (We) authorize transmittal of copies of this form to the recipients named in item 19 and the use of this form by the CSS as described under "General Information." I (We) agree that to verify information reported, the CSS or any of the named recipients may request or obtain an official photostatic copy of our latest U.S. income tax return. I (We) further agree to provide, if requested, any other official documentation necessary to verify information reported.

Signature(s) of student ______________________ DATE

and spouse ______________________ DATE

WARNING: If this form is to be used in the process of establishing eligibility for federal student aid funds, you should know that intentionally false statements or misrepresentation may subject the filer to a fine or imprisonment, or to both, under provisions of the United States Criminal Code.

PARENTS' CERTIFICATION AND AUTHORIZATION

We declare that the responses to items 7, 8 and 9 and the parental information reported is true, correct, and complete. We authorize the use of this form by the CSS as described under "General Information." We agree that to verify the information reported, the CSS or any of the named recipients may request or obtain an official photostatic copy of our latest U.S. income tax return. We further agree to provide, if requested, any other official documentation necessary to verify the information reported.

To assist in the determination of financial need, we authorize the recipients named in item 19 to discuss the parents' information contained on this form with the student applicant. YES ☐ NO ☐

Signatures of both parents ______________________ DATE

(or guardian) ______________________ DATE

Be certain to enclose check or money order payable to CSS: $3.75 for the first institution or program listed and $2.25 for each additional listing.

It is [illegible]at you complete all items on the SFS according to the following instructions. This will help avoid delays in processing.

- Please type or print all entries in black or dark ink; do not use a pencil.
- Enter each response in the proper area. *Do not make entries outside boxes or enter more than one set of figures in a box.*
- Enter amounts in dollars; omit cents. For example, if wages salaries, tips, etc. are $1,432.78, enter $1,432.
- Do not leave dollar items blank. Enter a zero (0) where appropriate. Do not use words such as "unknown," "none," or "same."
- If the actual amounts are not available, provide your best estimates.
- Use (71) to explain all circled items and any unusual family circumstances.
- Sign and date the SFS.
- Fold the SFS so that the financial information is facing out.
- Be certain to enclose your check or money order, made payable to the CSS, with your completed form. Please do not send cash.

Student's Information

ITEMS 1-19: Enter the appropriate information.

ITEM 20: If you are reporting expenses and resources for a nine-month period (for example, September 1, 1975, through May 31, 1976), check the "nine months" box and enter your expenses and resources in 21-39 for the nine months you will be in school.
If you are reporting expenses and resources for a twelve-month period (for example, July 1, 1975, through June 30, 1976, or September 1, 1975, through August 31, 1976), check the "twelve months" box and enter your expenses and resources in 21-39 for the twelve months you will be in school.

Student's and Spouse's Expenses

ITEM 21: *If you listed more than one institution in 19, do not make any entry in the 1975-76 box.*

ITEMS 23 and 24: If you pay a combined room and board fee and cannot separate the charges, estimate the value of each. Do not enter a combined amount.

ITEM ㉖ : Enter all expenses associated with transportation — for example, car payments, upkeep, insurance, and bus fare — and itemize in (71).

ITEM ㉗ : Enter all medical and dental expenses not covered by insurance, plus medical insurance premiums. Itemize in (71).

ITEM ㉘ : Enter the total of all other expenses not previously listed, such as state and U.S. income taxes paid, child care, debt repayment, life insurance, necessary furnishings, recreation, dependent children's tuition at fee-charging elementary and secondary schools, child support, alimony, and personal expenses. Itemize in (71).

Student's and Spouse's Resources

ITEMS 32 and 33: Do not include College Work-Study Program earnings. If 1975-76 income for yourself or spouse is from more than one source, explain in (71).

ITEM ㉞ : Enter all taxable income not previously reported. Include dividends, interest, alimony received, estate or trust income, business or farm profit, rental or property income, appreciation or capital gains, pensions, annuities, and endowments. Itemize in (71).

ITEMS 35 and 36: Enter only the social security or Veterans Educational Assistance-GI Bill benefits received for educational purposes. Do not include these educational benefits in **37** or **59**.

ITEM ㊲ : Enter all other nontaxable income and benefits such as social security (noneducational benefits), welfare, child support, income tax refunds, gifts, inheritances, bequests, military subsistence and quarters allowances, allotments, aid from friends or relatives, and the estimated value of free housing, food, and services from anyone other than parents or spouse. Also include any benefits from Vocational-Rehabilitation, Manpower Development, War Orphans, or other similar types of assistance programs. Itemize in (71).

Student's and Spouse's Assets and Benefits

ITEMS 40 and ㊶ : If home or other real estate is part of a business or farm, enter a zero (0) and include value in **44**. If other real estate is income-producing, include only the net income received in **34**.

ITEM ㊺ : Do not enter mortgages on home and other real estate, business indebtedness, and previously incurred educational loans. However, if spouse is no longer in school and is repaying educational loans, enter the unpaid amount of the loans. Do not include amounts reported in **28**.

Parents' Information

ITEMS 46-52: Enter the appropriate information.

ITEM 53: Enter the number of dependent children from the appropriate line of the exemptions section of your 1974 U.S. income tax return, Form 1040 or Form 1040A. Do not leave blank.

ITEM (54) : Enter the number of all children whether or not you claim them as exemptions for tax purposes. Be certain to include the student. Do not leave blank and do not enter zero.

ITEM (56) : Enter the number of other dependents from the appropriate line of the exemptions section of your 1974 U.S. income tax return, Form 1040 or Form 1040A. Do not leave blank. Indicate in (71) your relationship to the other dependents and the dollar amount of support you provide annually. Do not include yourself or your spouse.

Parents' Annual Income and Expenses

ITEM (58) : Enter total annual amounts only. Whenever an individual entry is from more than one source, itemize and give dollar amounts in (71). *If actual amounts for 1974 are not available, give your best estimate.* If the amounts entered for 1975 are lower by $1,000 or more than those given for 1974, explain in (71).

ITEM (58A) : For 1974, enter amount for each working parent from the "wages, salaries, tips, and other employee compensation" line of your 1974 U.S. income tax return, Form 1040 or Form 1040A.

ITEM (58B) : For 1974, enter net profit from business or farm as reported on 1974 IRS Schedule C (1040) or Schedules F and D (1040). If you are a partnership or corporation, enter your share of the net profit reported on IRS Form 1065 or Form 1120 or Schedules F and D (1040).

ITEM (58C) : Enter all taxable income not previously reported. Include dividends, interest, rental or property income, appreciation or capital gains, pensions, annuities, endowments, alimony received, and estate or trust income.

ITEM (59) : Be certain to follow the instructions given above for **58**. Enter the total annual amount of social security, veterans, or welfare benefits received for *all* members of the family *except* those received for educational purposes by either the student or other members of the family. (The amount of educational benefits to be received by the student should be entered in **35** or **36**.) Also, enter unemployment compensation, child support received, military subsistence and quarters allowances, allotments, gifts, inheritances, bequests, aid from friends and relatives, and other nontaxable income such as free housing, food, and services.

ITEM (60) : For 1974, enter amount from the "employee business expense" line of your 1974 U.S. income tax return, Form 1040. If you own income-producing real estate, include tax-deductible business expenses on that real estate.

ITEM (62) : Include such emergency or unusual expenses as payments for alimony, child support, natural disasters not covered by insurance, termite control, unreimbursed tuition for parents' education, nursing-home care, funerals, legal fees, unreimbursed job-related moving expenses, and water, street, and sewer assessments (installation only). *Do not include any other types of expenses.*

ITEM 63: For 1974, enter amount from the "income tax" line of your 1974 U.S. income tax return Form 1040 or Form 1040A. Enter a zero (0) when no tax was paid. Do not enter state, local, real estate, or self-employment taxes, or total taxable income.

ITEM 64: Enter your state income tax paid for 1974. Enter a zero (0) when no tax was paid. Do not enter federal, local, real estate, or self-employment taxes, or total taxable income.

Parents' Assets and Indebtedness

ITEMS 65 and (66) : If home or other real estate is part of a business or farm, enter a zero (0) and include the value in **69**. If other real estate is income-producing, include the total income received in **58C**.

ITEM (70) : Do not include any expenses for 1974 already entered in **61** and **62**. Include such debt outstanding from 1973 or before as past medical and dental expenses; remaining business indebtedness if business dissolved; funeral expenses; legal fees; educational indebtedness for parents' education; unreimbursed job-related moving expenses; natural disasters not covered by insurance; personal loans for down payment of property or investments entered in **65**, **66**, **68**, or **69**; liens, and living expenses if business failure, prolonged illness, or unemployment have depleted assets and forced indebtedness. *Do not include any other type of debt outstanding.*

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ATTACHMENT A-4

SOCIAL WORK SERVICE PERSONNEL

1. John Simmons, MSW, ACSW (Director)
2. Ernest D. Cooley, MSW, ACSW
3. Phylis Arnow, MSW
4. Mary Monahan, MSW
5. Laura Museo MSW
6. Maria Terehume MSW
7. Ruth Scult, MSW, ACSW

Attachments B-1 and B-2 were removed for confidentiality reasons.

ATTACHMENT C - 1

ENGLISH SCHEDULE - February 2 through 28, 1976

8:00 to 11:00	Basic English (all groups)
12:00 to 2:00	Basic English (groups 1 to 4)
2:00 to 4:00	Basic English (groups 5 to 8)
4:00 to 6:00 (daily 8:00 to 12:00 Saturdays	1. Review of questions raised by the students pertaining to the morning English Lecture. 2. Additional material presented in the form of Medical English Lessions. Quizzes based on the basic English lession (these quizzes were of the reading comprehension and listening comprehension variety.) Additional training in English usage centered around words that are pronounced alike, (minimal parts) American slang, idioms, material presented for discussion from independent reading done by the students. (newspapers, magazines) 3. Language drills for pronounciation

Teaching Materials

1. Defense Language Institute English Lessons; 12,000; 14,000; 21,000; 23,000 series
2. Defense Language Institute Quiz (written and taped) appropriate to the 12,000; 14,000; and 23,000 series
3. Medical English using Medical English Volume I by Donald J. Lachowicz: lessons 3 through 12
4. English to Vietnamese translation of segments from item 3 through 10
5. Audio-tapes (Medical Lectures)
6. Audio-tapes (English)

ATTACHMENT C-2

ENGLISH COURSE FACULTY

1. Helen M. Choat, B.A., A.M.
2. William Peter Foster, B.A., M.S. Ed.D.
3. Mary Annette Palmer, B.S., M.A.
4. William J. Whelan, M.A. (Education) M.A. Modern Language
5. Harald E. Fonghner, B.A.
6. Louis S. Bedrock, M.A.
7. Daniel McCarty, M.A.
8. Mr. Petkov, M.S. (English)
9. Heinrich M Zweifel, M.A. (English)
10. Jonathan Steere, A.B., M.A.
11. Robert Roak, B.A., M.A.

ATTACHMENT C-3

English Course

List of Tests

1. American Language Placement Tests #25 and #26
2. A Comprehensive English Language Test for speakers of English as a second language (CELT. The CELT has discrete vocabulary, structure, aural components.
3. Medical Test administered in English and Vietnamese

ATTACHMENT C-4

Instructor: Robert Roak

Student A - His Oral comprehension and expression are both very good. He is able to use American idioms without appearing to force them. He speaks at a normal native rate and can understand when spoken to if the speaker is clear even if his speech is fast. He is enthusiastic and gregarious and this is an obvious asset in his learning of colloquial English. Although a late-comer he should have no trouble with the English exam and will probably be exempted from the morning and early afternoon classes. His pronounciation although intelligible still needs considerable attention.

Student B - He has improved in these several weeks, but still has a long way to go before he can communicate easily in colloquial English. His vocabulary is good but his pronounciation is weak. He has particular trouble with the long vowel sounds, not only with the quantity but also with the quality of the sound. His class participation is weak. I am not sure if his hesitancy is due to his weakness in English communication or to general shyness

Student C He has scored consistently high on his tests. His comprehension of spoken and written English is good. His retiring personality makes it difficult to evaluate his spoken English. Except for four days when he was absent to visit his sick child he has been excellent in attendance and interest.

Student D - He is perhaps the most serious minded in this group. He works hard in his daily preparation and his made significant strides in his oral comprehension and pronounciation. He can retell stories easily and with relative accuracy. He still has difficulties with his intonation. His gregarious personality has helped him achieve as well as he has. His attendance and enthusiasm are both excellent.

Student E - As the leader of the group Ton has exhibited both good linquistic and leadership skills. His comprehension is excellent and he has developed a high degree of fluency. He can retell stories easily and is an animated partner in a dialogue. He is anxious to improve his English and has done a good job improving his pronounciation.

Student F - He is a strong student who is making good progress with his English. Although his weak pronunciation especially with several critical sounds, makes it difficult to understand him, he has shown good effort in class. He seems to be one of the students who is most prone to use Vietnamese, as soon as class is over. His oral comprehension seems to be improving His enthusiasm and attendance are both excellent.

Student G - He is perhaps the weakest student in this group. He realizes his weaknesses, however, and is trying to correct them. He has also indicated interest in continuing his English lessons after the medical lectures begin. It is obvious that his level of oral comprehension is below that of the class as soon as one begins to question him. He still has serious pronounciation problems. In spite of the fact he missed several days due to a trip to visit his family in Boston, his enthusiasm is high.

Language Evaluations of Vietnamese Doctors

William Foster

1. Dr. is slightly above average for the class in oral fluency. He has some difficulty with English pronunciation, but does quite well with the structure, despite occasional lapses. He can, however, carry on a "free" conversation and apparently understands native-speakers well. He will continue to need additional practice in using English in the formulation of his thoughts.

2. Dr. has considerably more difficulty in the use of English, and is probably slightly below, or just at, average for the class. While pronunciation is something of a problem, it is overshadowed at the moment by English structures. He is able to communicate in English, but not easily. He is however a conscientious student and could profit from additional directed instruction.

3. Dr. is above average in English usage, but still has some basic errors in his conversation. Pronunciation presents a problem for him, as does stress and intonation. His attendance, although good, has not been overly regular, and thus might profit most from regular interaction with English-speaking colleagues.

4. Dr. is average in English for the class, although he doesn't seem to have had as much practice in the use of English as some of the others. Pronunciation is adequate for the stage he is at, but he has difficulty constructing full statements.

5. Dr. pronunciation is above par for the class, but he does make several errors in the formulation of statements in conversation, particularly with tenses. He appears to be quite diligent about studying English and should learn quickly. His conversational abilities are quite adequate.

6. Dr. appears to do better on written tests of English than his oral abilities would indicate. He probably has more difficulty than any of the others in the class with both constructing and pronouncing statements, and will continue to need individual attention, perhaps in the form of a tutor. Being seemingly older than some of the others, the interference of Vietnamese sound patterns in his English is particularly extensive. His vocabulary is, however, very good, and he appears to know English grammar when it is presented in writing. As noted, conversation is difficult for him.

7. Dr. is quite competent in English, and further practice or instruction should be aimed at refining his skills and correcting those errors that he has not yet eliminated. His pronunciation, for the class, is superior.

8. Dr. is probably the best of the class in his acquired abilities in English. His vocabulary is extensive, pronunciation good, and is quite capable of sustained conversation. As in the above case, his need is to refine his usage so as to incorporate more difficult structures.

9. Dr. is among the most of the outspoken in the class and thus gets quite a bit of practice. His level of English is good, for the class, but is at the stage where he needs to consciously formulate each construction in order to avoid error. He has some problem with certain sounds, particularly the /th/of "there." Stress and intonation are also serious problems for him.

10. Dr. is a new student, having only started attendance late this week. In general, she appears quite good in English, with a definite French cast to her pronunciation and stress patterns. Her conversational ability is good enough to allow her to recognize errors and to request corrections and advice.

General: In general, the class varies from about a low intermediate to a low advanced level. Abilities in understanding English exceed those in constructing English conversation, but, in either case, are beyond the elementary level. Some basic errors remain for all the students (such as tag questions, "there" as a subject, and so on) although each seems to be making considerable progress. Pronunciation and word stress remain the most difficult of the problems to be corrected. Some students could profit greatly from additional individual instruction by, for example, an English-speaking student enrolled in the college.

HEINRICH M. ZWEIFEL
GROUP 7
2-19-76

EVALUATION REPORT

Student I

VERBAL COMMUNICATION: GOOD
ORAL COMPREHENSION : VERY GOOD
VOCABULARY : GOOD
PRONUNCIATION : IMPROVING (FAIR-GOOD) BUT REQUIRES CLOSE ATTENTION
PARTICIPATION : VERY ACTIVE
TOEFL : HIS CHANCE OF SUCCESS IS GOOD

Student II

VERBAL COMMUNICATION: VERY GOOD
ORAL COMPREHENSION : VERY GOOD
VOCABULARY: : EXCELLENT
PRONUNCIATION : GOOD
PARTICIPATION : VERY ACTIVE
TOEFL : SHOULD HAVE NO PROBLEMS

Student III

VERBAL COMMUNICATION: GOOD
ORAL COMPREHENSION : VERY GOOD
VOCABULARY : GOOD
PRONUNCIATION : GOOD
PARTICIPATION : VERY ACTIVE
TOEFL : SHOULD PASS

Student IV

VERBAL COMMUNICATION: IMPROVING (FAIR-GOOD)
ORAL COMPREHENSION : GOOD
PRONUNCIATION : HAS IMPROVED (FAIR-GOOD)
VOCABULARY: : GOOD
PARTICIPATION : GOOD
TOEFL : FAIR CHANCE OF SUCCESS, PERHAPS LOW PASS

IN MY OPINION, DR. DOES NOT NEED TO CONTINUE WITH BASIC MORNING CLASSES. HE SHOULD PERHAPS STILL ATTEND THE EARLY AFTERNOON SESSIONS IN ORDER TO GET SOME EXTRA TRAINING TOWARDS TOEFL.

Student V

VERBAL COMMUNICATION: VERY GOOD
ORAL COMPREHENSION : VERY GOOD
VOCABULARY : VERY GOOD
PRONUNCIATION : GOOD
PARTICIPATION : VERY ACTIVE
TOEFL : SHOULD SUCCEED

Student VI

VERBAL COMMUNICATION: FAIR, IMPROVING
ORAL COMPREHENSION : FAIR, IMPROVING
VOCABULARY : GOOD
PRONUNCIATION : IMPROVING (FAIR-GOOD)
PARTICIPATION : GOOD, AFTER INITIAL RELUCTANCE (SHYNESS?)
TOEFL : IF HE KEEPS IMPROVING, HE HAS A FAIR CHANCE OF SUCCESS, PERHAPS LOW PASS.

DR. SHOULD CONTINUE WITH BASIC MORNING TRAINING.

Student VII

VERBAL COMMUNICATION: FAIR, SOME IMPROVEMENTS
ORAL COMPREHENSION : IMPROVING (FAIR-GOOD)
VOCABULARY : IMPROVING, GOOD
PRONUNCIATION : IMPROVING (FAIR), REQUIRES CLOSE ATTENTION
PARTICIPATION : GOOD
TOEFL : MIGHT NEED SOME ADDED TRAINING TO SUCCEED.

DR. SHOULD CONTINUE WITH BASIC MORNING CLASSES.

Student VIII

VERBAL COMMUNICATION: HAS SOME DIFFICULTIES
ORAL COMPREHENSION : IMPROVING (FAIR), REQUIRES CLOSE ATTENTION
VOCABULARY : IMPROVING (FAIR)
PRONUNCIATION : SOME PROGRESS, BUT REQUIRES CLOSE ATTENTION
PARTICIPATION : IMPROVING AFTER INITIAL RELUCTANCE (SHYNESS?)
TOEFL : WITHOUT EXTRA TRAINING, HIS CHANCES OF SUCCES ARE SLIM.

DR. SHOULD CONTINUE WITH BASIC MORNING CLASSES.

Student IX

VERBAL COMMUNICATION: IMPROVING (FAIR-GOOD)
ORAL COMPREHENSION : IMPROVING (FAIR-GOOD)
VOCABULARY : GOOD, HAS MADE PROGRESS
PRONUNCIATION : IMPROVING, BUT REQUIRES CLOSE ATTENTION
PARTICIPATION : ACTIVE, EAGER TO LEARN
TOEFL : MIGHT NEED SOME EXTRA TRAINING IN ORDER TO SUCCEED.

DR. SHOULD CONTINUE WITH BASIC MORNING CLASSES.

Instructor: W.J. Whelan

Dr. has improved. He tries relatively hard in class but he is reticent to speak out, perhaps because of his age. He does not comprehen well at all English spoken at a normal speed. He is incapable of formulating original sentences or questions but works well with the printed word. At the rate of his current progress I see severe difficulty ahead for him.

Dr. is exceptional. Every consonant sound we have covered he has mastered well. He is constantly trying in class and repeats to himself even when I am working with another student. His avowed goal of speaking as well as a native within one year may come true. I forsee success for him. If he can't make out well, no one in the group can.

Dr. is hard for me to evaluate. He is the oldest in the group (49) and tries extremely hard. He is having the most difficult time of all with consonant sounds but if trying will do it, eventually he will succeed. I don't know, however, if he can in one month. Also he is hesitant to question when he doesn't know -- it is more personality than anything I feel. His test scores may be misleadingly high--but then I may be evaluating him too early.

Dr. is excellent. His English sound is as good as anyone I have. He is quick thinking and has a greater ability to think on his feet without the written word than anyone I have. He isn't working out of class as hard as some but probably doesn't neet it. Above all I think his successwill depend on his willingness to go to 100% English as much of the time as he can. I foresee success for him.

Dr. has improved relatively as much as anyone. He has tried extremely hard in class and I feel badly he isn't better. His test scores are probably accurate but if we can bear with him a little longer I think he will be receptive because he works at it and he does so consistently. Overall his English is weak, but I can't at this time evaluate where he will be in two weeks or a month in all honesty.

Dr is the "sleeper" in my group. While his test results aren't significantly better, he is. His participation in class is excellent. He has had a lot of success and whether it will be sufficient I don't really know. His biggest single problem is conceptualizing quickly the spoken word. I think he may surprise me and do well in the long run.

Dr. is good. He has linquistic ability beyond most. He needs a lot of the spoken word - tapes, T.V., radio - because he has a hesitation between listening, comprehending and expressing But, he is a worker. And, I feel confident he will do well.

Dr. is a real student. Nothing escapes him. He notes everything. He constantly is practicing in class. He is strong and gets stronger by the day. If Dr. doesn't succeed something is wrong with the system. I think he'll be the best or one of the very best in the entire group.

Dr. s ability to form some consonant sounds --th, d,t, and ch, especially is poor. He does not actively and aggressively try in class. I question how hard he works outside of class. There is an overall improvement but not as much as there should be. His one week absence hurt him greatly. I foresee great difficulty with his comprehending regular speed English lectures.

Dr. faces severe problems. He is very quiet by nature and fears expressing himself even when others aroung him are in a relaxed manner. Getting him to speak out is extremely hard. His English comprehension of the spoken word is very weak. He tries, but only moderately -- or that is the way I read it. I do not foresee success for him in the long run.

4-1

Verbal communication - Very good
Listening comprehension - Excellent
Vocabulary- Good
English structure - Fair
Pronunciation - Very good
Class participation excellent
Interest- excellent
Attendance - Excellent

With more work in structures and vocabulary, chances for TOEFL are good, Speaks rapidly and with ease, but makes structural mistakes.

4-2

Verbal communication - Fair
Listening comprehension - very good
vocabulary - excellent
English Structure-Fair
Pronunciation- Excellent
Class Participation,- Excellent
Interest - Excellent
Attendance- Good

Needs more conversational practice, chances for passing TOEFL are good

4-3

Verbal Communication - Good
Listening Comprehension - Good
Vocabular Fair
English Structure - Good
Pronunciation - Fair
Class Participation - Excellent
Interest - Excellent
Attendance - Fair

Needs additional work in all areas. Chances would be good with more work and practice

4-4

Verbal communication - very good
listening comprehension - excellent
vocabulary - excellent
English structure - very good
Pronunciation- very good
class participation - very good
Interest - excellent
Attendance - excellent

Chances for TOEFL are very goo, speaks slowly, but correctly

4-5

Verbal communication- good
listening comprehension - very good
Vocabulary - Fair
English Structure - Good
Pronunciation-Very good
Class participation- Excellent
Interest- Excellent
Attendance - excellent

Chances for TOEFL are good with more vocabulary, structure and conversational practice. Good improvement

4-6

Verbal Communication- Good
Listening comprehension - very good
vocabulary - good
English structure - Fair
Pronunciation- very good
Class participation- very good
Interest - excellent
Attendance - Excellent

chances for passing TOEFL are good with more structure and conversational practicw

4-7

Verbal Communication - Excellent
Listening Comprehension - Excellent
Vocabulary - very good
English structure - very good
Pronunciation- excellent
Class Participation - excellent, when he attended
Interest - Fair
Attendance - Fair
Chances for TOEFL are good

4-8

Verbal communication - good
Listening comprehension- Fair
Vocabulary-excellent
English Structure - Fair
Pronunciation - Fair
Class Participation - excellent
Interest - Excellent
Attendance - Excellent

Needs additional remedial work before taking TOEFL. Needs pronunciation, conversation and listening comprehension practice

4-9

Verbal communication - good
Listening comprehension - excellent
vocabulary - very good
English structure- fair
Pronunciation - good
Class Participation - excellent
Interest - excellent
Attendance - excellent

Needs more work in structure. Chances for passing TOEFL are very good.

4-10

Verbal Communication - Good, there has been much improvement
Listening comprehension - Fair, although there has been great improvement
Vocabulary - Fair, there has been improvement
English Structure - Poor
Pronunciation - Poor
Class Participation - excellent
Interest- excellent
Attendance - excellent

Needs additional practice in all areas. I have seen much progress in these three weeks, although test scores do not indicate this. I think there may be "testing Problems" because he told one he didn't have time to finish.

4-11

Poor - attended only one class. Impossible to evauate; however, test scores indicate very good chances of passing TOEFL

4-12

Poos- attended only two classes. Impossible to evauate, however, test scores indicate good chances of passing TOEFL

ATTACHMENT C-5

SPECIAL REVIEW FOR I[illegible]OCHINESE PHYSICIANS

TEST SCORES

ALCPT-25			ALCPT-26			CELT-VA			CELT-LA			CELT-SA		
2/ 3	2/ 14	3/ 1	2/ 3	2/ 14	3/ 1	2/ 3	2/ 14	3/ 1	2/ 3	2/ 14	3/ 1	2/ 3	2/ 14	3/ 1
77	76	81	60	81	80	61	-	51	38	42	56	37	47	64
-	61	91	-	78	89	-	83	87	-	86	92	-	68	73
79	84	90	75	89	90	79	-	89	46	76	80	63	70	77
91	92	92	86	93	93	81	-	80	90	100	98	93	92	96
78	81	-	68	73	-	55	-	-	60	72	-	45	47	-
63	75	90	68	73	90	41	-	91	46	70	88	45	55	96
79	87	91	71	79	93	77	-	84	58	78	90	65	66	81
84	89	96	85	94	92	72	-	85	76	90	94	56	65	77
63	77	75	59	69	71	79	-	85	42	66	74	61	61	68
82	91	92	85	96	96	89	-	92	94	98	100	85	91	96
73	75	92	68	73	90	67	-	89	46	44	76	53	56	80
75	80	88	72	90	91	60	-	83	48	60	74	56	55	79
65	65	76	61	71	75	59	-	72	40	46	78	36	40	53
53	76	86	74	69	82	65	-	75	62	56	74	49	52	55
76	87	93	72	86	88	83	-	92	68	82	88	59	59	81
80	91	87	74	89	83	63	-	92	66	78	84	49	43	85
65	85	89	66	89	93	61	-	83	66	64	90	40	46	88

79	89	86	73	80	88	75	-	84	52	68	70	75	78	85
81	95	-	79	94	-	97	-	-	76	96	-	87	83	-
80	93	90	79	90	93	68	-	85	70	88	94	77	68	73
81	91	91	82	97	92	74	-	80	72	86	94	56	61	68
80	93	95	80	93	90	83	-	88	78	76	92	61	66	77
69	84	87	81	91	91	99	-	99	66	78	78	60	74	79
64	69	88	65	81	82	61	-	72	46	62	64	53	48	71
-	50	98	-	71	86	-	75	96	-	74	78	-	53	69
75	81	83	74	90	90	80	-	81	50	62	66	59	62	68
83	96	95	88	100	100	85	-	89	92	98	100	93	91	93
74	80	85	69	81	88	80	-	75	54	70	70	56	64	72
71	68	96	62	69	81	84	-	96	38	40	80	60	78	80
88	95	93	82	96	92	95	-	97	78	90	98	84	85	93
62	83	92	73	79	83	73	-	97	94	80	98	53	43	77
54	57	82	54	56	87	33	-	63	34	44	66	35	38	49
77	77	86	74	86	87	79	-	91	50	56	66	72	75	73
69	77	87	72	80	85	63	-	71	56	66	80	47	46	72
76	77	82	66	81	88	47	-	61	58	68	86	48	64	67
65	81	85	62	81	85	60	-	85	48	64	82	44	52	77
79	83	88	81	91	92	96	-	95	52	78	76	75	87	84
73	83	88	67	86	89	40	-	49	54	60	68	55	62	80
79	81	89	68	90	84	68	-	83	48	58	76	56	43	87
69	73	81	59	76	82	61	-	84	58	54	80	41	47	57

67	79	80	69	87	80	60	-	83	42	60	72	41	61	85
55	52	69	55	64	81	55	-	56	38	52	52	53	43	59
80	91	82	78	90	90	75	-	81	68	86	88	51	56	64
66	69	82	57	80	82	31	-	71	46	50	78	45	49	71
63	68	89	53	81	80	29	-	83	46	58	80	29	47	64
66	71	83	60	79	84	68	-	76	44	42	62	43	42	77
41	53	84	58	59	82	59	52	75	34	50	60	44	37	71
67	67	92	65	81	95	49	-	87	56	58	96	60	60	88
85	96	95	83	94	93	96	-	97	80	90	98	83	90	95
76	89	89	77	96	89	80	-	87	70	74	68	57	69	73
86	91	91	81	91	89	69	-	75	76	90	94	65	68	76
-	56	-	-	78	-	-	61	-	-	72	-	-	55	-
72	88	91	72	90	85	81	-	83	64	78	84	67	62	85
64	68	80	59	76	87	48	-	83	46	64	84	41	44	57
80	97	90	86	90	93	81	-	88	62	86	92	67	72	69
73	79	85	69	77	81	75	-	80	52	50	68	45	42	85
80	85	88	87	96	92	76	-	88	86	84	90	80	83	91
79	100	88	75	91	86	78	-	91	70	80	90	61	60	89
69	47	90	65	70	90	49	73	75	42	52	76	56	44	89
77	89	92	79	90	89	60	-	68	58	82	88	60	69	80

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ATTACHMENT D-1

STUDENTS WHO WITHDREW FROM THE COURSE

1. 3-9-76
2. 3-9-76
3. 3-9-76
4. 3-19-76
5. 3-19-76
6. 3-19-76
7. 3-19-76
8. 3-26-76
9. 3-26-76
10. 3-26-76
11. 3-26-76
12. 4-16-76

ATTACHMENT D-2

MARCH

VIETNAMESE ECFMG REVIEW COURSE

TIME	MONDAY 1	TUESDAY 2	WEDNESDAY 3	THURSDAY 4	FRIDAY 5
8-9	EXAMINATION	Anatomy and Physiology of the G.I. Tract	Peptic Ulcer Dr. Clearfield	Malabsorption	Portal Hyper-tension Dr. Clearfield
9-10				Dr. Clearfield	Cultural Orientation Course
10-11		Dr. Krishan	Pancreatitis Dr. Dinoso		
11-12			Protein Metabolism Dr. Krishan		
12-1		Dysphagia			
1-2	EXAMINATION	Dr. Clearfield	Protein Metabolism Dr. Krishan	Granulomatous Enterocolitis Dr. Goldstein	Anatomy and Physiology of Liver Dr Clearfield
2-3			Diverticular Disease Dr. Ward	Ulcerative Colitis Dr Goldstein	Liver function Tests Dr. Clearfield
3-4		Neoplastic GI Disease Overview		Surgery in Peptic Ulcer Dr. Perlman	Upper GI Neoplasms
4-5		3-4:30 Dr. Perlman			3-4:30 Dr. Perlman

Saturday - 10-1 - Review of the week's presentations - Krishan

MARCH

VIETNAMESE ECFMG REVIEW COURSE

TIME	MONDAY *8	TUESDAY 9	WEDNESDAY10	THURSDAY 11	FRIDAY 12
8-9	Hepatitis	Drugs and Liver Disease Dr. Dinoso	Nutrition: General Principles Dr. Krishan	8:30-10 Surgical Biliary Tract	
9-10	Dr. Asper	Radiology of GI Tract	Disorders of Nutrition Dr. Krishan	Disease Dr. Perlman	Cultural Orientation Course
10-11	Cirrhosis of the liver Dr. Krishan	Dr. Kricun	Carbohydrate Metabolism Dr Krishan		
11-12			Fat Metabolism Dr. Pairent	Basic Concepts In statistics Dr. Benarde	
12-1					
1-2	Jaundice Dr. Krishan	CHO Metabolism	Lipid Storage Diseases Dr. Kaye	Frequency Distribution Graphs Dr. Benarde	Population Dynamics Dr. Benarde
2-3		Dr. Krishan	Hyperlipidemia Dr.Fleischmajer	Tests of Statistical Significance Dr. Benarde	Accident Prevention Dr Benarde
3-4	Pancreatic Hepatic and Biliary CA Dr. Perlman			Colorectal Tumors 3-4:30	Acute Abdomen Syndrome 3-4:30
4-5	Misc. GI and abdominal tumors Dr. Perlman		Proctology Dr. Paviledes	Dr. Perlman	Dr Krishan

VIETNAMESE ECFMG REVIEW COURSE

MARCH

TIME	MONDAY 15	TUESDAY 16	WEDNESDAY 17	THURSDAY 18	FRIDAY 19
8-9	Synoviol Analysis Dr. Miller	Hypothesis testing Dr. Benarde	EXAMINATION		Radiology of Joint Disease Dr. Kricun
9-10	Occupational Diseases Dr Weiss	Tests of Statistical Significance Dr. Benarde		Transplantation Principles Dr. Krishan	Cultural Orientation Course
10-11				Rheumatoid Arthritis Dr. Zarro	
11-12	Control of the Environment Dr Benarde	Degenerative Joint Disease Dr. Fisher		Other Rheumatic Diseases Dr. Zarro	
12-1					
1-2	Communicable Diseases and Their Control Dr. Kaplan	The Immune System Dr. Krishan	EXAMINATION	Auto immune disease Dr. Zarro	
2-3				Immuno deficiency diseases Dr. Krishan	Tests in Immunology Dr. Krishan
3-4	GI Bleeding Surgical Aspects	Hernia Dr. Saris		Concepts of Musculoskeletal Injury I Dr. Lowe	Concepts of Musculoskeletal Injury Dr. Lowe
4-5	3-4:30 Dr. Perlman				Gout & Pseudo gout Dr. Promisloff

MARCH

VIETNAMESE ECFMG REVIEW COURSE

TIME	MONDAY 22	TUESDAY 23	WEDNESDAY 24	THURSDAY 25	FRIDAY 26
8-9	Suppurative Arthritis Dr. Zarro	EXAMINATION	Headache Dr. Swami	Autonomic Nervous System Dr. Krishan	Seizure Disorders Dr. Swami
9-10	Polymyositis Dr. Krishan		Cerebro-vascular disease	Neuro Diagnostic Techniques	Cultural Orientation course
10-11	Joint Involvement in systemic Disease Dr. Zarro		Dr. Swami	Dr. Swami	
11-12	Scleroderma Dr.Fleischmajer			Peripheral Nerve Injury Dr. Plaut	
12-1					
1-2	Neuroanatomy Dr. Swami	EXAMINATION	Neurosurgical disorders	Neuromuscular Disorders Dr.Krishan	Menigitis Dr. A.Schwartz
2-3			Dr. Olsen	Myopathies Dr.Krishan	Encephalitis Brain Abcess Dr. A.Schwartz
3-4				Surgery of Arthritis Dr. Berman	Extremity Injuries I Dr. Lowe
4-5					4:00 - 7:00 pm Review Session Dr. Krishan

March TIME	MONDAY 29	TUESDAY 30	WEDNESDAY 31	April THURSDAY 1	FRIDAY 2
8-9	Optic Atrophy Dr. Tolat	The red eye Dr. Tolat	EXAMINATION	Tests in Hematology Dr Major	Eye in systemic disease Dr. Tolat
9-10	Multiple Sclerosis & Syringomyelia Dr. Swami	Glaucoma Dr. Tolat			Cultural Orientation Course
10-11	Hydrocephalus Dr. Swami	Subacute combined degeneration Dr. Swami		Lymphomas	
11-12	Tumors of the CNS Dr. Cevallos	Diseases of Basal Ganglia Dr. Swami		Dr. Conroy	
12-1					
1-2	Neuro cutaneous syndrome Dr. Swami		EXAMINATION	Therapy of Neoplasms	Microcytic Anemia Dr. Major
2-3	Peripheral Neruopathy Dr. Swami	Fe, B12 Folate Metabolism Dr. D. Major		Dr. Conroy	Ovulomacroytic Anemia Dr. Major
3-4	G.I. Exam Review	Hemoglobin Physiology Dr. Major			
4-5	Dr. Krishan				4:00 to 6:00 Immunology Exam Review Dr.Krishan

Saturday 8-9 Problems of Micturition - Khanna 10-12 Polycythemia
9-10 Neck Masses, cysts - Krishan

VIETNAMESE ECFMG

TIME	APRIL 5 MONDAY	6 TUESDAY	7 WEDNESDAY	8 THURSDAY	9 FRIDAY
8-9	Acute Leukemia Dr. Contory	Platelet Disorders Dr. Hertz			
9-10	Chronic Leukemia Dr. Conroy		Fluid & Electrolytes Dr. Krishan		CULTURAL ORIENTATION COURSE
10-11		EXAMINATION	Acid/Base Physiology Dr. Krishan		
11-12	Pulmonary TBC Dr. Johnston				
12-1			Acid base Disorders Dr. H. Lyons		
1-2	Pulmonary Fibrosis Dr. Johnston	Anatomy & Physiology of the lungs		Hypo/hyper Natremia Dr. Schwartz	Inherited Renal Disease Dr. Swartz
2-3	Pleural Effusion Dr. Oslick	Dr. Shinnick	CA Lung Dr. Weiss	Hypo/Hyper Kalemia Dr. Schwartz	
3-4	Hemoptysis Dr. Shinnick	Inflammatory Lung Disease Dr. Griesback	COPD Dr. Griesback	Fractures of spine & pelvis Dr. Lowe	Back & Neck Injuries Dr. Lowe
4-5		Emergency Medical Management Dr. Oaks			4:00-6:00 Hematology Exam Review Dr. Krishan

9-10 Nephrotic Syndrome - Dr. Krishan
10-11 Review of the Week's presentation Dr. Krishan

VIETNAMESE ECFMG REVIEW COURSE

APRIL

TIME	MONDAY 12	TUESDAY 13	WEDNESDAY 14	THURSDAY 15	FRIDAY 16
8-9	The Kidney in Systemic Diseases & Drugs in Renal Disease	Antihypertensive Therapy	EXAMINATION	Diabetes Dr. Lavine	GOOD FRIDAY
9-10	Dr. Lowenthal	Dr Lowenthal			
10-11	Hypertension			Prostatism & Prostatitis Dr. Gonick	
11-12	Dr Swartz				
12-1					Free Day
1-2		Pituitary Disorders Dr. Krishan		Coagulation Physiology Dr. Lefferts	
2-3	Diuretics Dr. Lowenthal	Hemolytic Anemia Dr. Major	Thyroid Disorders Dr. Major	Disorders of Coagulation Dr. Lefferts	
3-4	Pituitary Physiology Dr. Krishan			Hand Injuries Dr. Lowe	
4-5		Pancytopenia Dr. Major			

Holy Saturday - Free Day

VIETNAMESE ECFMG REVIEW COURSE

APRIL

TIME	MONDAY 19	TUESDAY 20	WEDNESDAY 21	THURSDAY 22	FRIDAY 23
8-9	Hypoglycemia Dr. Lavine	Pulmonary Embolism Dr. Coodley		Adrenal Physiology Dr. Rose	Dwarfism Dr. Rose
9-10	Parathyroid Disorders ↑	Genetics Dr. Fuscaldo ↑		Adrenocortical Disorders Dr. Rose	← Cultural Orientation Course →
10-11	Dr. Krishan ↓	↓	Genetics ↑	Testicular Physiology Dr. Rose	
11-12	Hypercalcemia Dr. Krishan	Multiple Endocrino-Pathies Dr. Wright	↓ Dr. Fuscaldo	Testicular Disorders Dr. Rose	
12-1					
1-2	Shock and Hemorrhage ↑	Diagnositc Procedures in Pulmonary dis. Dr. Dovnarsky	← EXAMINATION →	Genetics	
2-3	Dr.Perlman ↓			Dr. Fuscaldo	
3-4					Pulmonary Exam Review
4-5					Dr. Krishan

SATURDAY

8-9 Urinary Calculus Disease Dr. Gonick
9-11 Major Trauma - Dr. Gain 2-4 Bronchial Asthma -Krisha
12-3 Review of the Week's presentation Dr Krishan

APRIL

VIETNAMESE ECFMG REVIEW COURSE

TIME	MONDAY 26	TUESDAY 27	WEDNESDAY 28	THURSDAY 29	FRIDAY 30
8-9	Kidney Development and physio. Dr. Fernandes	Fungal Infections Dr A Schwartz	Anticoagulants Dr. Promisloff	The conducting System of the Heart Dr. Carver	Aortic Valve Disease Dr. Carver
9-10	Urinalysis Dr. Fernandes	Peripheral Vas. Disease Dr. Naide		Congestive heart failure Dr. Carver	Cultural Orientation Course
10-11	Acute Glomerulo-Nephritis Dr. Fernandes		Chest x-rays Dr Kricun	Pericardial Disease Dr. Carver	
11-12	Acute Renal Failure Dr .Fernandes	Disecting Aneurysm Dr. Mintz		Cardiomyopathies Dr. Mintz	
12-1					
1-2	EXAMINATION	Chronic renal Failure	Anatomy and Physiology of the heart	Congenital Heart Disease	Mitral Stenosis Dr. Carver
2-3		Dr. Fernandes	Dr. Carver	Dr. Eshaghpour	Mitral Insufficiency Dr. Carver
3-4			Endocrine exam Review		
4-5	Sarcoidosis Dr Coodley		Dr. Krishan		

SATURDAY

9-10 Overview of Minor Surgery Dr. Carver

10-12 Review of the Week's Presentation - Dr. Krishan

VIETNAMESE ECFMG REVIEW COURSE

MAY

TIME	MONDAY 3	TUESDAY 4	WEDNESDAY 5	THURSDAY 6	FRIDAY 7
8-9	Ischemic Heart Disease		Approach to Patients with Infections Dr.A.Schwartz	Cardiology Exam review	Systemic Mycosis Dr.A.Schwartz
9-10	Dr. Carver	Traumatic Heart Disease Dr. Mintz	Antibiotic Therapyl Dr.A.Schwartz	Dr. Krishan	Cultural Orientation Course
10-11	Cardiac Arrhythmias	EXAMINATION			
11-12	Dr. Carver		Staph Infections Dr. Kaplan		
12-1					
1-2	Other EKG Abnormalities Dr. Carver	Examination		Anaerobic Infections Dr Asper	Herpes Virus Infections Dr. A.Schwartz
2-3	Bacterial Endocarditis Dr.A.Schwartz		Venereal Diseases	Rickettsiosis Dr. Asper	
3-4			Dr.A. Schwartz	Epidemiology Exam review	Skin Infections Dr A Schwartz
4-5			Strep. Infections	Dr. Krishan	

Saturday 9:00-1:00 Review of the week's presentations

Vietnamese ECFMG Review Course

May TIME	10 MONDAY	11 TUESDAY	12 WEDNESDAY	13 THURSDAY	14 FRIDAY
8-9		Digitalis Dr. Mintz	Antiinflammatory Agents Dr. Lowenthal	Drug Inter-Actions Dr. Lowenthal	
9-10	Ear Infections Dr. Kaplan	Vasodilators Dr. Mintz	Analgesics Dr. Lowenthal	Hypoglycemics Dr. Lowenthal	↕ Cultural Orientation Course
10-11	Dermatoses Dr. Shore ↕	Sympathomimetic Dr. Mintz	Hypnotic Dr. Krishan	Parastic Infections Dr. Kaplan ↕	
11-12		Sympatholytics Dr. Mintz	Antiarrhythmics Dr. Mintz		
12-1					
1-2	Skin Tumors Dr. Shore	Parasympatho-Mimeticslytics Dr. Krishan	Shock Dr. Major	Microbiologic Techniques Mr. Morges	Serologic Techniques Mr. Morges
2-3	Interpretations of Cultures Dr. Kaplan		Coma Dr. Major		Poisoning Dr. Krishan
3-4	Pharmo Kinetics Dr. Lowenthal		Drug Side Effects Dr. Krishan	Antidepressants Dr. De Gregorio	Protozoal Infections Dr. A. Schwartz
4-5					

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Saturday - 10:00 to 1:00 Review of the Week's Presentations

Dr. Krishan

Vietnamese ECFMG Lectures

May TIME	17 MONDAY	18 TUESDAY	19 WEDNESDAY	20 THURSDAY	21 FRIDAY	22
8-9	Physiology of Menstruation and Menopause Dr. H. Kotwal	Infertility Dr. S. Gupta	Laparoscopy, Endoscopy, Colposcopy Dr. Kotwal	Gynecic Endocrinology I Dr. H. Kotwal	Medical Complications of Pregnancy Dr. Gupta	
9-10	Benign Uterine Disease Dr. H. Kotwal	Third Trimester Bleeding & PPH Dr. S. Gupta	Prematurity and Twins Dr. S. Gupta	Gynecic Endocrinology II Dr. H. Kotwal	CULTURAL ORIENTATION COURSE	9-11 Nucleic Acids - Dr. Alexander
10-11	Pelvic Anatomy Dr. P. Gnanes	Prenatal Care & Fetal Monitorind Dr. Pontarelli	Amino Acid Metabolism Dr. Angstadt			
11-12	Vaginitis, Vulvar lesions, VD Dr. P. Gnanes	High Risk Pregnancy Dr. Pontarelli		Enzymes Dr. Baggott		
12-1						
1-2	Ca Vagina, Cervix Uterus, Tubes Dr. P. Gnanes	Proteins & Amino Acid Metabolism Dr. Baggott	Ectopic Pregnancy Dr. H. Kotwal	Vitamins & Nutrition Dr. Baggott	Bioenergetics Carbohydrate & Fat Metabolism	
2-3	Ovarian Tumors & Adnexal Masses Dr. P. Gnanes		Hydatiform mole and Choriocarcinoma Dr. H. Kotwal	Purinine Pyrimidines Hemoglobin Dr. Devlin	Dr. Conover	
3-4	Contraception Sterilization Dr. H. Kotwal	Labor, delivery, abnormal Presentation Dr. Mukherjee	Forceps & Cesarian Section Dr. S. Gupta			
4-5		First Trimester Bleeding Dr. Mukherjee			Pregnancy Termination Dr. R. Gibbons	

Vietnamese ECFMG Lectures

May TIME	24 MONDAY	25 TUESDAY	26 WEDNESDAY	27 THURSDAY	28 FRIDAY	29
8-9			Medical Complications of Pregnency Dr. Gupta		Diabetes Dr. Kaye	
9-10		Development Dr. Vanace	Jaundice in the Older Child Dr. Kaye	Fever of Unknown Origin Dr. Caplan	CULTURAL ORIENTATION COURSE	
10-11		Ph Poisoning Dr. Waldman	Neurologic Exam in Childhood Dr. Mitchell	Neurodignostic techniques Dr. Mitchell		
11-12			Child with Seizures Dr. Mitchell	Learning Disorders Dr. Mitchell		
12-1		Upper Respiratory Dr. Palmer				
1-2	Immunizations Dr. Waldman	Basic Immunology Dr. Hann	Genetics Dr. Moshang	Child with Connective Tissue Disorders Dr. Vanace	UTI Dr. Falkner	
2-3	Diseases of the Skin Dr. Scott ↕	Clinical Immunology Dr. Hann	Genetics Dr. Monshang	Growth Problems Dr. Moshang	Hematuria Dr. Falkner	
3-4		Lower Respiratory diseases Dr. Palmer			Nephrotic Syndrome Dr. Falkner	
4-5	Jaundice in the Neonate Dr. Chawla	Respiratory diseases in the Neonate Dr. Chawla	Child with Anemia Dr. Wang	Child with Bruises Dr. Wang	Surgical disease in the Neonate Dr. Chawla	

VIET REVIEW

JUNE

TIME	MONDAY	TUESDAY 1	WEDNESDAY 2	THURSDAY 3	FRIDAY 4
8-9					
9-10		OB/GYN			
10-11		Examination		Gen. Medicine Examination	Pharmacology
11-12			Fluid Electrolyte, acid base Review		Examination
12-1			Dr. Krishan		
1-2		OB/GYN EXAM		Exam Review	Exam Review
2-3		1:00 to 4:30	EKG Cardiology Review	Dr. Promisloff	
3-4		Review	Dr. Carver		Dr. Krishan
4-5		Dr. Kotwal			

June

VIET REVIEW

TIME	MONDAY 7	TUESDAY 8	WEDNESDAY	THURSDAY	FRIDAY
8-9		7:00-8:30 Surgery Exam Review Dr. Perlman			
9-10		Medicine Review			
10-11	Pediatric	Dr. Krishan			
11-12	Exam				
12-1					
1-2	Pediatric				
2-3					
3-4	Exam Review Dr. Kaplan				
4-5					

ATTACHMENT D-4

Indo-Chinese Review Medical Faculty

Krishan Bharadwaja, M.D.	Associate Professor	Medicine
Harris Clearfield, M.D.	Professor	Gastroenterology
Morton Perlman, M.D.	Associate Professor	Surgery
Vincente Dinoso, M.D.	Associate Professor	Gastroenterology
Stephen Ward, M.D.	Assistant Professor	Gastroenterology
Robert Goldstein, M.D.	Assistant Professor	Gastroenterology
Ronald Asper, M.D.	Assistant Professor	Infectious Diseases
Morrie Kricun, M.D.	Associate Professor	Diagnostic Radiology
Frederick Pairent, Ph.D.,	Professor	Medical Education
Robert Kaye,M.D.	Professor	Pediatrics
Raul Fleischmajer, M.D.	Professor	Dermatology
C. A. Pavlides, M.D.	Senior Instructor	Surgery
Melvin Benarde, Ph.D.	Professor	Community Medicine
J. Martin Kaplan	Assistant Professor	Pediatrics
Demetrius Saris, M.D.,	Associate Professor	Surgery
Mark Fischer, M.D.	Resident	Medicine
Howard Miller, M.D.	Teaching Fellow	Medicine
William Weiss, M.D.,	Professor	Medicine
Robert Promisloff, M.D.	Resident	Medicine
Vincent Zarro, M.D.	Associate Professor	Rheumatology
Kumar Swami, M.D.	Assistant Professor	Neurology
Arnold Berman,M.D.	Professor	Orthopedic Surgery
Andrew Schwartz, M.D.	Associate Professor	Infectious Diseases
Pratima Tolat, M.D.	Assistant Professor	Opthamology
Henry Cevallos, M.D.	Clinical Senior Inst.	Neurosurgery
avid Major, M.D.	Associate Professor	Medicine
James Conroy, M.D.	Associate Professor	Hematology
Robert Johnston, M.D.	Professor	Pulmonary Diseases
Theodore Oslick, M.D.	Assistant Professor	Pulmonary Diseases
James Shinnick, D.O.	Assistant Professor	Pulmonary Diseases
Lee Hertz, M.D.	Senior Instructor	Medicine
Russell Griesback, D.O.	Senior Instructor	Pulmonary Diseases
Wilbur Oaks, M.D.	Professor	Medicine
Harvey Lyons, M.D.	Assistant Professor	Nephrology
Charles Swartz, M.D.	Professor	Nephrology
Alan Schwartz, M.D.	Associate Professor	Nephrology
David Lowenthal, M.D.	Associate Professor	Nephrology
Paul Gonick, M.D.	Professor	Urology
Geoffrey Lefferts, M.D.	Assistant Professor	Medicine
Leslie Rose, M.D.	Associate Professor	Endocrinology
Martin Plaut, M.D.	Clinical Asst. Prof.	Neurosurgery
James Dovnarsky, M.D.	Assistant Instructor	Pulmonary Diseases
Daniel Wright, M.D.	Teaching Fellow	Medicine
Axel Olsen, M.D.	Professor	Neurosurgery
Stephen Lowe, M.D.	Resident	Orthopedic Surgery
Robert Lavine, M.D.	Assistant Professor	Medicine
Kathryn Fuscaldo, M.D.	Professor	Medicine
ichael Fernandes, M.D.	Assistant Professor	Nephrology
Eugene Coodley, M.D.	Professor	Medicine
David Naide, M.D.	Assistant Professor	Medicine
Gary Mintz, M.D.	Resident	Medicine

Joseph Carver, M.D.	Resident	Medicine
Esagh Esaghpour, M.D.	Associate Professor	Pediatrics/Cardiology
Ronald Shore	Assistant Professor	Dermatology
Mr. Wayne Morges	Instructor	Microbiology
Homi B. Kotwal, M.D.	Assistant Professor	Obstetrics & Gynecology
Panchadcharam Gnanes, M.D.	Senior Instructor	Obstetrics & Gynecology
Santosh Gupta, M.D.	Assistant Professor	Obstetrics & Gynecology
Domenic Pontarelli, M.D.	Professor	Obstetrics & Gynecology
Manishi Mukherjee, M.D.	Senior Instructor	Obstetrics & Gynecology
James Baggott, Ph.D.	Assistant Professor	Biological Chemistry
Carol Angstadt, Ph.D.	Assistant Professor	Biological Chemistry
Thomas Devlin, Ph.D.	Professor	Biological Chemistry
Thomas Conover, Ph.D.	Associate Professor	Biological Chemistry
Richard Gibbons, M.D.	Assistant Professor	Obstetrics and Gynecology
Sydney Waldman, M.D.	Associate Professor	Pediatrics
T.F. McNair Scott, M.D.	Professor	Pediatrics
Harbhajan Chawla, M.D.	Assistant Professor	Pediatrics
Peter Vanace, M.D.	Associate Professor	Pediatrics
Judy Palmar, M.D.	Senior Instructor	Pediatrics
Suhung Hann, M.D.	Assistant Professor	Pediatrics
Thomas Moshang, M.D.	Associate Professor	Pediatrics
Michael Mitchell, M.D.	Assistant Professor	Pediatrics Neurology
Bonita Falkner, M.D.	Assistant Professor	Pediatrics
Annie Wang, M.D.	Assistant Professor	Pediatrics

ATTACHMENT D-5

MEDICAL TUTORIAL FACULTY

Patrick Costello, M.D.

Howard Miller, M.D.

Larry Pressman, M.D.

Jayne Starrs, M.D.

Robert Promisloff

Joseph Fabrizio

Kumar Swami, M.D.

Mark Fisher, M.D.

Richard Orose

Paul Roderick

Steven Fox, M.D.

Paul Waibel

ATTACHMENT D-6

MEDICAL TESTS SCORES

GEN. MED		HEMATOLOGY		G.I.		Gen. Medicine		SURGERY	
Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
36	58	51	70	41	68	26	29	36	50
52	76	58	80	51	70	43	60	--	--
49	75	58	75	61	70	--	--	--	--
52	78	65	85	57	70	46	57	--	--
47	70	44	66	29	60	30	50	38	54
51	70	20	60	40	58	23	58	37	57
63	88	41	68	55	65	--	--	--	--
63	90	61	90	51	70	--	--	54	60
44	68	31	58	43	62	25	54	31	51
55	70	--	--	--	--	--	--	--	--
39	60	51	70	53	65	41	59	--	--
40	62	48	70	47	65	46	61	41	49
29	56	51	67	60	72	32	52	34	60
32	58	48	71	53	60	34	54	39	62
51	70	58	69	48	65	39	69	--	--
42	68	34	58	52	61	32	60	41	63
50	68	37	66	47	68	48	70	50	70
41	65	14	60	49	70	40	55	46	64
36	62	54	70	40	56	--	--	28	45
46	70	54	72	47	65	42	60	34	50

MEDICAL TESTS SCORES

ENDOCRINOLOGY		ENDOCRINE		CARDIOLOGY		PULMONARY		THERAPUETICS	
Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
34	48	37	68	34	48	41	60	23	40
--	--	--	--	--	--	--	--	--	--
--	--	--	--	--	--	--	--	--	--
--	--	--	--	--	--	--	--	--	--
30	62	31	58	37	56	49	70	34	48
24	38	30	60	19	30	45	70	32	50
--	--	--	--	--	--	--	--	--	--
60	78	37	68	--	--	--	--	--	--
30	40	36	64	46	58	48	68	43	90
--	--	--	--	--	--	--	--	--	--
--	--	29	58	34	60	45	59	40	63
46	65	--	--	41	59	52	64	41	59
34	50	34	59	32	50	37	66	41	60
30	41	41	64	40	60	31	54	27	58
--	--	--	--	--	--	--	--	--	--
20	32	35	60	46	70	57	75	43	68
50	60	40	62	48	70	51	66	36	70
22	30	39	64	41	61	58	70	54	75
22	30	38	68	39	59	40	60	38	60
30	45	34	52	40	56	43	51	40	58

MEDICAL TESTS SCORES

GENETICS		EPIDEMIOLOGY		PULMONARY		NEPHROLOGY			
Pre	Post	Pre	Post	Pre	Post	Pre	Post		
40	50	37	65	41	55	24	60		
--	--	--	--	--	--	--	--		
--	--	--	--	--	--	--	--		
--	--	--	--	--	--	--	--		
7	20	30	50	41	50	36	68		
7	25	33	50	36	50	42	70		
23	38	--	--	--	--	--	--		
23	38	--	--	--	--	--	--		
37	50	44	78	41	68	46	74		
--	--	--	--	--	--	--	--		
--	--	33	60	32	55	30	45		
--	--	26	68	41	87	40	70		
16	40	11	30	36	48	30	48		
7	15	26	38	41	67	50	75		
--	--	--	--	--	--	--	--		
26	40	37	50	40	60	38	56		
36	70	30	46	37	54	32	48		
20	40	37	52	45	50	56	75		
36	54	37	51	41	60	48	65		
36	60	30	45	50	68	50	75		

GEN. MEDICINE		HEMATOLOGY		G.I.		GEN. MEDICINE		SURGERY	
PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
26	48	41	60	48	70	28	50	29	58
36	56	24	40	47	68	38	55	--	--
55	75	--	--	--	--	--	--	--	--
63	80	51	75	48	56	57	75	68	80
43	70	34	50	55	75	43	70	38	68
61	78	--	--	60	80	--	--	54	75
43	52	58	75	47	70	23	48	31	50
52	75	48	70	39	45	--	--	--	--
--	--	--	--	--	--	--	--	--	--
60	75	---	--	--	--	--	--	--	--
41	58	48	60	41	75	31	50	25	42
50	60	61	75	53	72	44	60	50	70
43	60	58	70	52	75	41	75	38	60
43	60	--	58	--	53	--	60	26	40
31	45	--	40	--	50	--	55	27	44
42	50	37	70	49	68	41	48	26	58
54	20	--	--	--	--	--	--	--	--
38	40	61	80	20	40	26	38	35	50
56	75	--	--	--	--	--	--	--	--

ENDOCRINOLOGY		ENDOCRINE		CARDIOLOGY		PULMONARY		THERAPEUTICS	
PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
52	76	46	63	43	57	50	58	47	47
20	38	--	46	37	50	40	54	--	50
--	--	--	--	--	--	--	--	--	--
--	--	--	--	--	--	--	--	--	--
--	--	--	--	--	--	--	--	--	--
34	51	40	54	51	60	49	73	45	61
--	--	--	--	--	--	--	--	--	--
28	51	29	47	32	50	41	60	41	71
28	40	45	80	31	45	47	67	41	62
--	--	--	--	--	--	--	--	--	--
10	28	35	45	35	60	53	68	45	63
--	--	--	--	--	--	--	--	--	--
32	43	42	50	47	58	55	69	34	76
42	57	32	47	--	50	--	40	29	45
46	74	39	64	49	63	52	59	36	47
34	57	41	67	41	53	52	60	41	61

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GENETICS		EPIDEMIOLOGY		PULMONARY		NEPHROLOGY				
PRE	POST	PRE	POST	PRE	POST	PRE	POST			
40	60	9	28	50	75	50	70			
--	44	26	39	41	50	40	60			
--	--	--	--	--	--	--	--			
--	--	--	--	--	--	--	--			
--	--	--	--	--	--	--	--			
23	31	26	40	50	70	48	70			
--	--	--	--	--	--	--	--			
23	61	41	60	31	45	40	65			
30	45	30	48	50	70	60	76			
--	--	--	--	--	--	--	--			
26	39	37	58	23	45	30	60			
--	--	--	--	--	--	--	--			
36	43	30	47	45	60	43	68			
40	55	33	57	61	60	32	64			
36	60	33	47	36	50	40	66			
30	40	15	22	40	42	35	60			

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ATTACHMENT D-7

EVALUATION SHEET

Date:____________

NAME OF THE STUDENT:____________

RATER: JM Fabrizio

1. Verbal communication: good

2. Listening comprehension: poor

3. Vocabulary: — fair

4. English structure: good

5. Pronunciation: good

6. Participation: good

7. Interest: good

8. Attendance: good

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes_____ no ✓

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor____ adequate ✓ good____ excellent____

EVALUATION SHEET

Date: 4/4/76

NAME OF THE STUDENT: ____________________

RATER: M. Fabrizo

1. Verbal communication: good

2. Listening comprehension: good

3. Vocabulary: — fair

4. English structure: fair

5. Pronunciation: fair -

6. Participation: good

7. Interest: Very good

8. Attendance: good

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes____ no X

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor____ adequate____ good X excellent____

	ENDOCRINOLOGY		ENDOCRINE		CARDIOLOGY		PULMONARY		THERAPEUTICS			
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST		
	14	20	30	50	32	58	40	65	36	60		
	--	--	28	60	29	45	41	60	34	60		
	--	--	--	--	--	--	--	--	--	--		
	33	50	37	65	38	70	42	68	34	61		
	--	--	27	55	39	42	--	--	36	58		
	46	80	--	--	--	--	--	--	--	--		
	36	60	39	58	42	60	44	72	40	66		
	--	--	--	--	--	--	--	--	--	--		
	--	--	--	--	--	--	--	--	--	--		
	--	--	--	--	--	--	--	--	--	--		
	32	60	38	48	40	52	47	53	40	63		
	28	50	--	--	48	60	51	75	34	60		
	16	68	35	75	32	60	43	70	40	62		
f	26	42	26	42	27	50	40	60	31	58		
	26	42	30	45	27	41	38	60	40	70		
ıh	32	40	44	50	35	50	55	60	50	70		
	--	--	--	--	--	--	--	--	--	--		
	22	45	30	50	41	60	49	70	34	74		
	--	--	--	--	--	--	--	--	--	--		

	GENETICS		EPIDEMIOLOGY		PULMONARY		NEPHROLOGY					
	PRE	POST	PRE	POST	PRE	POST	PRE	POST				
	16	40	22	50	18	50	25	60				
	3	28	30	50	32	--	30	62				
	--	--	--	--	--	--	30	62				
	13	35	8	15	31	52	48	70				
	36	54	30	40	54	80	40	72				
	--	--	--	--	--	--	--	--				
	36	54	41	60	45	70	50	80				
	--	--	--	--	--	--	--	--				
	--	--	--	--	--	--	--	--				
	--	--	--	--	--	--	--	--				
	36	60	30	50	54	70	60	80				
	--	58	22	50	--	50	48	59				
	20	36	44	72	50	65	58	68				
	--	40	41	60	32	45	40	55				
	--	50	30	52	32	45	50	65				
h	40	58	26	40	54	70	60	68				
	--	--	--	--	--	--	--	--				
	26	42	22	38	50	75	50	80				
---	--	--	--	--	--	--	--	--				

GEN. MED.		HEMATOLOGY		G.I.		GEN. MEDICINE		SURGERY			
PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST		
50	70	48	68	64	82	44	80	46	78		
52	70	41	55	60	78	51	55	45	60		
50	68	48	75	52	64	45	58	42	60		
50	70	--	--	--	--	--	--	--	--		
38	46	68	78	41	65	33	50	41	70		
44	50	48	72	45	65	51	59	57	68		
35	55	54	70	49	70	35	58	32	68		
46	70	--	50	--	50	46	60	42	61		
37	--	51	--	41	--	35	--	35	--		
48	60	44	67	49	58	48	61	52	70		
51	70	--	--	--	--	--	--	--	--		
46	60	44	61	64	88	32	56	42	60		
28	50	34	51	48	67	28	48	30	57		
54	75	51	57	53	60	46	59	45	58		
42	66	68	88	47	75	39	60	35	58		
40	61	41	59	48	64	29	43	28	57		
74	90	44	68	47	68	52	45	--	--		
26	40	10	20	43	54	14	35	19	28		
56	76	-- -	--	--	--	--	--	--	--		

	ENDOCRINOLOGY		ENDOCRINE		CARDIOLOGY		PULMONARY		THERAPEUTICS	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
	30	50	33	40	47	52	46	60	34	50
	34	46	43	50	41	70	57	78	52	68
	46	62	19	40	35	70	46	69	45	63
	--	--	--	--	--	--	--	--	--	--
	16	40	36	52	38	60	55	74	40	60
t	28	40	43	65	41	58	53	67	38	58
	28	54	45	70	48	59	42	64	38	60
u	50	70	--	--	--	--	--	--	--	--
	34	--	36	--	49	--	41	--	41	--
	26	40	44	71	46	59	53	67	41	66
	--	--	--	--	--	--	--	--	--	--
	48	59	39	61	39	49	52	73	36	65
	36	48	37	60	35	59	52	67	29	36
	40	60	43	54	46	59	44	20	--	50
	26	38	40	57	42	60	45	55	34	44
	20	47	35	52	41	60	49	61	40	63
	--	--	--	--	--	--	--	--	--	--
	14	28	13	40	23	44	24	39	29	41
	--	--	--	--	--	--	--	--	--	--

	GENETICS		EPIDEMIOLOGY		PULMONARY		NEPHROLOGY				
	PRE	POST	PRE	POST	PRE	POST	PRE	POST			
	30	48	37	51	54	62	52	65			
	30	34	44	58	50	70	42	68			
	--	40	48	65	50	70	44	50			
	--	--	--	--	--	--	--	--			
	36	52	26	50	50	70	55	75			
et	40	64	26	35	41	60	40	78			
	23	48	22	50	32	50	34	60			
au	--	--	--	--	45	--	--	--			
	10	--	--	--	32	--	--	--			
	33	41	26	35	32	50	30	60			
	--	--	--	--	--	--	--	--			
	36	47	44	62	36	70	38	64			
	16	40	48	71	50	68	38	59			
	33	46	44	68	--	50	--	--			
	23	50	30	38	50	59	58	75			
	20	30	33	50	27	38	40	60			
	--	--	--	--	--	--	--	--			
	13	26	26	39	32	49	30	50			
	--	--	--	--	--	--	--	--			

GEN. MED.		HEMATOLOGY		G.I.		GEN. MEDICINE		SURGERY	
PRE	POST	PRE	POST	PRE	POST	PRE	POST	PRE	POST
--	60	68	78	53	75	37	56	50	72
37	60	--	40	43	50	--	48	22	36
61	78	--	--	--	--	--	--	--	--
44	68	--	--	--	--	--	--	--	--
51	75	--	--	--	--	--	--	--	--
52	70	54	68	43	60	38	49	39	53
55	68	--	--	--	--	--	--	--	--
29	35	51	61	53	70	22	50	36	48
72	88	44	65	51	70	55	75	69	80
46	58	--	--	--	--	--	--	--	--
50	70	51	60	48	62	30	45	30	48
40	54	20	36	52	70	--	--	--	--
51	70	48	65	52	68	45	70	44	62
38	48	37	50	55	71	35	67	30	41
42	50	58	70	47	70	38	67	37	57
49	53	44	70	51	77	34	57	42	61

****

EVALUATION SHEET

Date: ____________

NAME OF THE STUDENT: ____________

RATER: ____________

1. Verbal communication: fair

2. Listening comprehension: Very good

3. Vocabulary: fair

4. English structure: fair

5. Pronunciation: good

6. Participation: Very good

7. Interest: excellent

8. Attendance: excellent

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes_____ ? no_____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor____ adequate____ good____ excellent [✓]

EVALUATION SHEET

Date: 4/23/76

NAME OF THE STUDENT: ____________

RATER: Mark Fisher MD

1. Verbal communication: fair, has difficulty expressing himself

2. Listening comprehension: good

3. Vocabulary: fair

4. English structure: good

5. Pronunciation: fair

6. Participation: fair - hesitates to actively voice opinion - probably from lack of confidence in English, not medicine

7. Interest: good

8. Attendance: good

9. Are the student's communication skills adequate for functioning in a clinical setting?

   yes ✓ no ____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

    poor ____ adequate ____ good ____ excellent ____

EVALUATION SHEET

Date: 4/27/76

NAME OF THE STUDENT: J

RATER: Mark Fisher (M2)

1. Verbal communication: good

2. Listening comprehension: fair

3. Vocabulary: adequate

4. English structure: fair

5. Pronunciation: fair

6. Participation: poor

7. Interest: poor

8. Attendance: poor

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes ✓ no _____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor ____ adequate ____ good ____ excellent ____

EVALUATION SHEET

Date: 4/23/76

NAME OF THE STUDENT: [redacted]

RATER: Mark Fishman

1. Verbal communication: good

2. Listening comprehension: good

3. Vocabulary: good

4. English structure: good

5. Pronunciation: fair

6. Participation: good

7. Interest: good

8. Attendance: good

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes ✓ no____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor____ adequate____ good____ excellent____

EVALUATION SHEET

Date: 4/11/76

NAME OF THE STUDENT: A

RATER: H Miller

1. Verbal communication:
   Very good
2. Listening comprehension:
   Very good
3. Vocabulary:
   " "
4. English structure:
   " "
5. Pronunciation:
   " "
6. Participation:
   " "
7. Interest:
   " "
8. Attendance:
   " "

I HAVE NEVER MET!

9. Are the student's communication skills adequate for functioning in a clinical setting?

   yes ✓ no____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

    poor____ adequate____ good____ excellent____

Passed ECFMG — but before that attendance 100% — Very bright & interested

EVALUATION SHEET

Date: 4/11/76

NAME OF THE STUDENT: [redacted]

RATER: A. Miller

1. Verbal communication:
ok

2. Listening comprehension:
ok

3. Vocabulary:
ok

4. English structure:
ok

5. Pronunciation:
ok

6. Participation:
ok

7. Interest:
ok

8. Attendance:
Poor but as of late is improving

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes ✓ no____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor____ adequate____ good____ excellent____

EVALUATION SHEET

Date: 9/11/76

NAME OF THE STUDENT: ______________ ______________

RATER: H Miller

1. Verbal communication:
good

2. Listening comprehension:
Good

3. Vocabulary:
Good

4. English structure:
Good

5. Pronunciation:
Good

6. Participation:
good

7. Interest:
Good

8. Attendance:
OK

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes ✓ no____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor____ adequate____ good____ excellent____

was transferred to my group & since beginning has been an interested stude
& very good.

EVALUATION SHEET

Date: 9/11/72

NAME OF THE STUDENT: ____________ ____________

RATER: H. Miller

1. Verbal communication:
Improving — Still needs work on expression

2. Listening comprehension:
Good

3. Vocabulary:
OK — but improving

4. English structure:
Mediocre —

5. Pronunciation:
OK — Needs some work

6. Participation:
Very good

7. Interest:
Very good

8. Attendance:
Outstanding

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes ✓ WITH A LITTLE WORK no____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor____ adequate____ good X excellent____

EVALUATION SHEET

Date:____________

NAME OF THE STUDENT:____________

RATER: R E [illegible] MD

1. Verbal communication: ADEQUATE

2. Listening comprehension: ADEQUATE

3. Vocabulary: POOR

4. English structure: POOR

5. Pronunciation: POOR

6. Participation: POOR

7. Interest: POOR

8. Attendance: POOR

9. Are the student's communication skills adequate for functioning in a clinical setting?

   CANNOT ASSESS yes____ no____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

    poor ✓ adequate____ good____ excellent____

EVALUATION SHEET

Date: ____________

NAME OF THE STUDENT: ____________

RATER: R.E. Orore

1. Verbal communication: ADEQUATE
2. Listening comprehension: ADEQUATE
3. Vocabulary: ADEQUATE
4. English structure: ADEQUATE
5. Pronunciation: ADEQUATE
6. Participation: POOR
7. Interest: GOOD
8. Attendance: POOR
9. Are the student's communication skills adequate for functioning in a clinical setting?

   yes ✓ no ____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

    poor ✓ adequate ____ good ____ excellent ____

EVALUATION SHEET

Date: ____________

NAME OF THE STUDENT: ______________________

RATER: R E Orore

1. Verbal communication: ADEQUATE

2. Listening comprehension: ADEQUATE

3. Vocabulary: POOR

4. English structure: ADEQUATE

5. Pronunciation: ADEQUATE

6. Participation: POOR

7. Interest: POOR

8. Attendance: POOR

9. Are the student's communication skills adequate for functioning in a clinical setting?

CANNOT MAKE JUDGEMENT, yes_____ no_____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor [✓] adequate____ good____ excellent____

EVALUATION SHEET

Date: 4/27/76

NAME OF THE STUDENT: ______________________

RATER: R E Orore

1. Verbal communication: ADEQUATE

2. Listening comprehension: ADEQUATE

3. Vocabulary: ADEQUATE

4. English structure: ADEQUATE

5. Pronunciation: ADEQUATE

6. Participation: POOR

7. Interest: GOOD

8. Attendance: POOR

9. Are the student's communication skills adequate for functioning in a clinical setting?

   yes ✓ no ___

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

    poor ___ adequate ✓ good ___ excellent ___

EVALUATION SHEET

Date: ____________

NAME OF THE STUDENT: ________ J   ________

RATER: Pressman

1. Verbal communication: Fair

2. Listening comprehension: Fair

3. Vocabulary: Fair

4. English structure: Fair

5. Pronunciation: Poor

6. Participation: good

7. Interest: good

8. Attendance: good

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes_____ [✓ no]

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor____ [✓ adequate] good____ excellent____

EVALUATION SHEET

Date: ____________

NAME OF THE STUDENT: ____________ ____________

RATER: Pressman

1. Verbal communication: Fair

2. Listening comprehension: Fair

3. Vocabulary: Fair

4. English structure: Fair

5. Pronunciation: Fair

6. Participation: good

7. Interest: good

8. Attendance: good

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes X no ____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor ____ adequate X good ____ excellent ____

EVALUATION SHEET

Date: ____________

NAME OF THE STUDENT: [redacted]

RATER: Pressma

1. Verbal communication: good

2. Listening comprehension: Fair

3. Vocabulary: good

4. English structure: good

5. Pronunciation: good

6. Participation: good

7. Interest: good

8. Attendance: good

9. Are the student's communication skills adequate for functioning in a clinical setting?

   yes [✓] no ____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

    poor____ adequate____ good____ excellent____

EVALUATION SHEET

Date: 4/4/76

NAME OF THE STUDENT: ____________ ____________

RATER: Provisloff

1. Verbal communication: Good

2. Listening comprehension: Good

3. Vocabulary: Fair

4. English structure: Fair

5. Pronunciation: Good

6. Participation: Good

7. Interest: Excellent

8. Attendance: Excellent

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes ✓ no ____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor ____ adequate ____ good ____ excellent ____

EVALUATION SHEET

Date: 4/4/76

NAME OF THE STUDENT: ______

RATER: Promisloff

1. Verbal communication: Good

2. Listening comprehension: Good

3. Vocabulary: Fair

4. English structure: Good

5. Pronunciation: Good

6. Participation: Fair

7. Interest: Good

8. Attendance: Excellent

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes [✓] no ____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor ____ adequate ____ good ____ excellent ____

EVALUATION SHEET

Date: 4/4/76.

NAME OF THE STUDENT: [redacted]

RATER: Provinshoff

1. Verbal communication: Good

2. Listening comprehension: Excellent

3. Vocabulary: Good

4. English structure: Good

5. Pronunciation: Good

6. Participation: Excellent

7. Interest: Excellent

8. Attendance: Excellent

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes ✓ no ____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor ____ adequate ____ good ____ excellent ____

EVALUATION SHEET

Date: 4/4/76

NAME OF THE STUDENT: ______________ ______________

RATER: ______________

1. Verbal communication: Good

2. Listening comprehension: Good

3. Vocabulary: Fair

4. English structure: Fair

5. Pronunciation: Good

6. Participation: Good

7. Interest: ~~Good~~ Excellent

8. Attendance: Excellent

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes ✓ no ____

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor____ adequate____ good____ excellent____

EVALUATION SHEET

Date: 4/2/76

NAME OF THE STUDENT:

RATER: P RODERICK M.D.

1. Verbal communication: FAIR (best of the Group)

2. Listening comprehension: GOOD

3. Vocabulary: FAIR

4. English structure: POOR - FAIR

5. Pronunciation: FAIR

6. Participation: GOOD

7. Interest: GOOD

8. Attendance: GOOD

9. Are the student's communication skills adequate for functioning in a clinical setting?

   yes___ no ✓

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

    poor___ adequate ✓ good___ excellent___

EVALUATION SHEET

Date: 4/7/76

NAME OF THE STUDENT: ______________

RATER: P RODERICK M.D

1. Verbal communication: POOR

2. Listening comprehension: POOR - FAIR

3. Vocabulary: POOR

4. English structure: POOR

5. Pronunciation: POOR

6. Participation: FAIR (VERY Quiet)

7. Interest: GOOD

8. Attendance: GOOD

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes ____ no ✓

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor ____ adequate ✓ good ____ excellent ____

EVALUATION SHEET

Date: 4/2/76

NAME OF THE STUDENT: ______________________

RATER: P RODERICK MD

~~[illegible]~~ added to group 2wks ago

1. Verbal communication: POOR

2. Listening comprehension: ? (Quiet)

3. Vocabulary: ? (Quiet)

4. English structure: ? (Quiet)

5. Pronunciation: ? (Quiet)

6. Participation: POOR.

7. Interest: GOOD

8. Attendance: GOOD

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes_____ no ✓

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor ✓ adequate____ good____ excellent____.

EVALUATION SHEET

Date: 4/7/76

NAME OF THE STUDENT:

RATER: P RODERICK M.D.

added to group 2 wks ago

1. Verbal communication: POOR

2. Listening comprehension: POOR - FAIR

3. Vocabulary: POOR

4. English structure: POOR

5. Pronunciation: POOR

6 Participation: FAIR

7. Interest: GOOD

8. Attendance: GOOD

9. Are the student's communication skills adequate for functioning in a clinical setting?

yes____ no ✓

10. If question #9 was answered "no", has the progress of the student over the duration of the tutorial been:

poor____ adequate ✓ good____ excellent____

ATTACHMENT D-8

/

OTHER CONNECTIVE TISSUE DISORDERS

1) The connective tissue is actually normal and just shows the results of a disease process that is taking place somewhere else in the body.

2) A multi-system disease, characterized by exacerbations and remissions and a positive LE Prep or Antinuclear Antibody.

3) Fibrinoid necrosis, which is the deposition of eosinophilic amorphous material in and about the normal connective tissue.

4) Highly variable clinical picture due to multi-system involvement. Patient may note skin rash after exposure to the sun, hair loss, false positive serology, seizures, pleuritis, pericarditis, pyelonephritis, Raynauds' phenomenon, adenopathy, anemia, leukopenia, thrombocytopenia, pleural effusion, recurrent cystitis, myalgia, arthralgia and fever.

5) Usually, the 30-year-old female patient has been diagnosed as early as 2-years-old and in elderly patients where male involvement equals female involvement.

Possible familial transmission.

Disease often revealed under stress.

30% of patients with discoid lupus go on to systemic lupus erythematosis.

May present as rheumatoid arthritis.

6) May exacerbate pre-existing renal insufficiency leading to renal failure.

7) Arthritis and arthralgia.

8) 75%.

9) Positive Coombs' reaction.

Thrombolytic antibodies.

Circulating anticoagulants.

Biologically false positive serology.

Rheumatoid factor presence.

Decreased complement.

Cyroglobulins

10) Positive LE Prep and ANA.

11) Positive LE Prep implies patient's serum contains something that can alter nuclear material, predisposing it to phagocytosis.

Perform test by adding patient's serum to normal WBC and seeing if one or several WBC engulf nuclear material or other WBC.

12) One WBC engulfing nuclear material of another WBC.

13) Coat slide with source of nuclei.

Add patient's serum after diluting 1/10.

Incubate.

Wash slide.

Add anti-human gamma globulin which is fluorescent.

If patient serum is able to alter nuclei, they will fluoresce either a homogeneous or perinuclear pattern.

Positive in almost 100% of patients with systemic lupus erythematosis.

14) Renal failure.

15) Normal.

Lupus glomerulitis.

Lupus glomerulonephritis.

16) Treatment with high close steroids can prevent or arrest renal damage.

17) Renal function closely parallel urine analysis therefore, if urine analysis is negative, there is little chance of renal involvement. Biopsy is appropriate if there is clinical suspicion.

18) Rheumatoid arthritis.

Polymyositis.

Scleroderma.

Periarteritis nodosa.

Differential diagnosis is difficult because of overlap in signs, symptoms and presentations.

19) Skin, synovial tissue, internal organs, esophagus, lungs, heart, small intestine, kidney.

1/3 of patients have positive ANA.

20) Polymyositis is a diffuse inflammatory disease of striated muscle.

Dermatomyositis is polymyositis with skin involvement.

21) Violaceous eruption involving face, eyes and "V" shaped area of neck.

22) Muscle weakness 100% of time.

Elevation of muscle enzymes LDH, SGOT, CPK and aldolase.

EMG shows myopathy and minor neuropathy.

Biopsy of muscle shows inflammation.

23) Complex connective tissue disorder, characterized by inflammation of medium and small arteries.

GOUT AND PSEUDOGOUT

1. Crystal deposition diseases

2. a. one or more acute attacks of gout due to urate crystal deposition
   b. deposition of urate crystal somewhere in the body
   c. kidney stones of uric acid

3. Deposition of sodium urate in subcutaneous tissue resulting in nodular masses usually on extensor surfaces

4. Elevated urate levels in blood stream

5. Uric acid is the result of breakdown of nucleic acid. The rate limiting step is the formation of inosinic acid, which is the basic compound in the formation of nucleic acids. From here the metabolic pathway proceeds to hypoxanthine and xanthine and finally to uric acid, the last two steps being catalyzed by xanthine oxidase. There is an important shunt pathway from hypoxanthine back to inosinic acid via HGPRT ase. If this shunt pathway is blocked, then uric acid levels may rise, resulting in tissue deposition.

6. For male 7 mg.%
   Premenopausal female 6 mg.% rising to 7 mg% post menopausal

7. Allopurinol, blocks conversion of hyposanthine to xanthine and xanthine to uric acid.

8. a. Deficiency of HGPRT ase causes a rise in uric acid levels, resulting in possible crystal deposition. An important conservation pathway
   b. Lesch-Nyhaun syndrome is associated with decreased HGPRTase

9. Urate levels greater than 10 mg.% increases the chance of a gout attack in 10 years.

10. Primary and secondary

11. Acute leukemia, polycythemia vera, diuretics

12. Over producers, under excretors

13. a. Over producers swamp the excreting mechanisms producing high urate levels
    b. under excretors do not excrete urate well, producing high urate levels

14. Acute gouty arthritis, tophi, kidney stones

15. Attempted metabolism of uric acid crystals by leukocytes, resulting in their destruction and release of inflammatory substances

16. Male disease, approximately 20 to 1, usually occurs in older population, occasionally in young.

17. Patient is perfectly alright until some event like excessive drinking, surgery, or even prophylactic gout treatment triggers an attack

18. Tophi on extensor surfaces and ears
History of previous attacks
Group II fluid in joints with urate crystals present

19. Tophi do not impair joint function but act as source of acute attacks

20. Acute synovitis
Present in several hours as acute inflammation
Gout is caused by urate cyrstal
Pseudogout is caused by calcium pyrophosphate dehydrate crystals

21. Degenerating cartilage, usually the knee

22. Associated with degenerative joint disease

23. Disease of elderly 50-60 year old, males slightly more than female

24. Linear deposition of crystals in articular cartilage

25. Group II fluid

26. Urate cyrstals have negative birefringence
Calcium pyrophosphate dehydrate crystals have positive birefringence

27. No acceptable difference, except pseudogout is used to describe the attacks of acute arthritis

28. Hyperparathyroidism, also old age, diabetes, mellitus,hypertension and atherosclerosis.

SPLENOMEGALY

1. Bacterial - Septicemias, TB, Typhoid
   Viral - Infectious Mononucleosis
   Protozoan - Malaria
   Fungus - Histoplasmosis

2. Malaria is most common infectious disease world - wide and almost always causes splenomegaly.

3. Rheumatoid arthritis
   Systemic Lupus Erythematosis
   Sarcoidosis

4. Congestive Splenomegaly
   1. Intrahepatic portal hypertension
   2. Extrehepatic portal hypertension - splenic & portal vein thrombosis
   3. Elevated pressure secondary to cardiac disease

   Increased pressure in splenic vein results in enlarged spleen

5. Banti's syndrome - no underlying cause can be demonstrated but spleen enlarges and becomes overactive

6. 1. Intrinsic and extrinsic hemolytic anemias
   2. Lymphoproliferative disorders
   3. Myeloproliferative disorders
   4. Hemoglobinopathies
   5. Iron-deficient anemia & megaloblastic anemias

7. Intrinsic - due to red cell defect; hereditary spherocytosis
   Extrinsic - due to extra RBC defect - immunohemolytic anemias or mechanical, as after heart valve replacement

8. Positive direct Coomb's test is associated with collagen vascular diseases, lymphomas

9. Lymphoproliferative disorders are those hematologic neoplasms resulting from plasma cell or lymphocyte precursors.

10. Myeloproliferative disorders are due to neoplasms of stem cells concerned with megakarocytes, granulocytes & red cells; i.e., acute and chronic granulocytic leuk, polycythemic vera, myelofibrosis with myeloid metaplasia

11. In children and some adults with longstanding iron deficiency or megaloblastic anemia, the spleen can be palpated.

12. Myeloid metaplasia, chronic myelogenous leukemia, some lymphomas

13. Start as low as the inguinal ligament

14. Splenic scans, arteriography

15. Hypersplenism develops when spleen becomes enlarged & begins to destroy RBCs & WBCs or platelets
    1. Bone marrow hypercellular
    2. Peripheral cytopenia
    3. Increased cell destruction
    4. Splenomegaly - present or absent

16. Idiopathic thrombocytopenic Purpura - all of the above with thrombocytopenia with or without anemia but spleen is not enlarged.

17. Decreased number of RBC's, WBC's and/or platelets

18. Spleen seems to be producing an antibody against platelets and is involved in their destruction

19. 1. History and physical examination - familial hemoglobinopathy, exposure to malaria - etc.
       Is patient febrile?
    2. CBC and reticulocyte count
    3. Biochemical profile, Coomb's test, ANA, etc.
    4. Flat plate of abdomen
    5. Spleen scan
    6. Bone Marrow aspiration & biopsy

20. 1. Examination of peripheral blood smear
    2. Stool for occult blood

21. 1. Infections - acute and subacute
    2. Collagen vascular and granulomatous disease
    3. Lympho and myeloproliferative disorders
    4. Neoplastic invasion (metastases
    5. Immunoresponse - serum sickness and drugs

22. Infections; viral and bacterial

23. Lymph nodes are hard, not movable. 1 cm in diameter, and rubbery in consistency.

24. Serum sickness and drugs, especially Dilantin

25. History and physical examination, peripheral smear; if suspicious lymph node biopsy and culture

26. Biopsy and culture of the lymph node

Vaccination and Immunization

1) Tetanus
2) Not because of bacteria, but the toxin it excretes
3) The toxin blocks the inhibitory postsynaptic potential allowing continuous firing of motor neurons, (both flexors and extensors) resulting in rigidity
4) Most potent of all toxin known
5) Once the toxin has reacted biochemically it can not be reversed
6) To make toxoid, you grow organism, collect toxin, heat treat toxin making it nontoxic but still antigenic
7) Booster need only be given at 10 year interval or if last vaccination was 5 years ago and patient is now recently exposure to tetanus
8) A local inflammatory reaction due to bound antibodies at site of injection
9) The toxin that the organism excretes produces tissue necrosis
10) The injection of Diphtheria toxin. If necrosis occurs in area of injection, then there is no antibody protection. Test should be used to check for protection against Diphtheria toxin
11) Should be given every 10 years
12) Children less than 1 to 2 years old
13) Vaccine made by grinding up organism. This results in low antibody levels, and increased reactions to toxoid
14) High fever, swelling, convulsions
15) Vaccination may not produce 100% immunity in all vaccinated
16) Encephalitis, Vaccinia Necrosum, Eczema Vaccinatum, Generalized Vaccinia, Accidental infection, Urticarial reactions
17) Live vaccine gives life long protection; protects gut, protects next individual. Hazards are producing disease in immunodeficient individuals
18) Encephalitis
19) 0.1% of all cases of measles
20) Occurs approximately 9 months after measles but may occur up to 10 years later. Results in decreased intelligence, involuntary motion, rigidity and eventually death
21) Immunity is short lived, allowing for infection resulting in rash, fever and pneumonia
22) Produces birth defects
Vaccine may produce transient arthritis or arthralgia
23) Immunise certain percentage of population hoping to protect other people

Streptococcal Disease

1. Outer capsule resistant to polymorphonuclear leukocytes and antibodies
   Cell wall which is antigenic
   Cytoplasm

2. Alpha - greenish discoloration of agar. No hemoglobin breakdown
   Beta - Clear zone of hemolysis around colony
   Gamma - no hemolysis

3. Beta hemolytic organisms and gamma hemolytic organism

4. Group
   A - Beta hemolytic
   B - Beta hemolytic, Neonatal sepsis
   C - Not important
   D - Nonhemolytic, gamma hemolytic, enterococcal, Sub-acute Endocarditis
   E - Not important

5. M protein is a compound in cell wall, it is antigenic and specific for organism. T protein is another antigenic substance, it is not used much.

6. Streptokinase converts Plasminogen to plasmin, allowing fibrinolysis, and breakdown of clot, spreading infection along fascial planes.
   Streptodornase - DNA ase
   Hyaluronidase - connective tissue lysing enzyme
   Erythrogenic toxin - scarlet fever rash
   Streptolysin O & S - Antigens

7. Erysypelas
   Puerperal fever
   Sepsis
   Neonatal sepsis
   Sub-acute Bacterial Endocarditis
   Acute Bacterial endocarditis

8. Impetigo
   Pharyngitis

9. Acute Rheumatic fever
   Acute Glomerulonephritis

10. Acute Rheumatic fever can only result from pharyngitis, whereas acute glomerulonephritis can result from pharyngitis or impetigo

11. The individual acquires no cross-over immunity from having any particular M type infection

12. Acute Rheumatic fever occurs in about 2-6 weeks after pharyngitis. Acute glomerulonephritis occurs in about 10 days after pharyngitis or 3 weeks after impetigo.

Prophylaxis is good in acute Rheumatic fever but not in acute glomerulonephritis due to pharyngitis or impetigo.

Acute Rheumatic fever is 100% preventable while acute glomerulonephritis may only be partially preventable.

13. High fever, sore throat, tongue rash (white to red strawberry) rash in creases of body, (axilla, inguinal area and antecubital fossa.)

Requires a phage converted group A Beta hemolytic streptococcus of any type.

Patterns of Disease
  Immunity to type 4 and toxin results in no disease
  Bacterial immunity only " " " "
  Immunity to toxin " " " " pharyngitis
  No immunity " " " " and scarlet fever

14. Dick test - inject toxin, area turns red and necroses.
Shultz Charlton - Antibody to toxin causes blanching in area of injection.

15. Culture giving alpha, beta, gamma hemolysis
If beta is it group A
Bacitracin disc inhibits group A

16. ASO titer rise 80% of patients
ASO, AH titer rise 90% of patients
ASO, AH, ASK titers rise 95% of patients

AH = Anti DNA ase, ASK= antistreptokinase
ASO - antistreptococcal O titers

17. Penicillin, IM, for more than 10 days, low titers of penicillin are needed

Benzathine Penicillin 600,000 units IM
Pen V or G 400,000 units PO q.i.d. x 10 days
If allergic to penicillin, Erythromycin q.i.d. or b.i.d.

18. Tetracycline is a broad spectrum drug. Produces resistant organism and stains teeth

Sulfa can not eradicate pharyngitis but can prevent acute rheumatic fever

19. Wash, mild soap, remove crust

If diffuse, widespread, use penicillin

Degenerative Joint Disease

1. There is no inflammatory reaction present.
2. Basic pathology is related to wear and tear of cartilage and replacement of adult cartilage by immature embryonic cartilage. Lipping of bone. The synovial fluid is of a noninflammatory nature.
3. Basically this is a disease of the elderly or of individuals who had traumatic injury to joints.
4. a) Joints most often involved are weight bearing joints, i.e. the knees, hips, low back, cervical, and the distal interphalangeal joints.
   b) Symptoms occur after 40 years of age if no history of trauma is present.

   No systemic symptoms, i.e. fever, anemia. May be pain on motion, relieved by rest. Morning stiffness disappears with use in 10 minutes. Localized tenderness, crepitation, deformity may be present.
5. Heberden's nodes occur at distal interphalangeal joint, usually symmetrically involved, nontender, due to lipping of phalangeal bones.
6. Laboratory studies usually negative, synovial fluid is of group I.
7. Trauma, infiltrative diseases of cartilage, obesity.
8. Narrowed joint space, lipping, cysts in cartilage.
9. Particular form of DJD due to inflammatory processes, occurs in menopausal women, but may occur in males.
10. a) Inflammation of distal interphalangeal joint. May appear to be rheumatoid arthritis.
    b) This disease progresses causing increasing joint deformity with decreasing inflammation. However, there is no loss of function.
11. Systemic lupus erythematosus
    Rheumatic fever
    Sympathetic effusion
    Hypertrophic pulmonary osteoarthropathy
    Resolving group II diseases
12. 95% of shoulder pain occurs outside actual glenohumeral joint, in surrounding muscles and bursae
    Sternoclavicular joint
    Acromioclavicular joint
    Subdeltoid bursae
    Glenohumeral joint space
    Subscapularis insertion
    Bicipital groove
    Supraspinatus insertion
13. Major bone: Sternum, clavicle, scapula, humerus
14. Fibrositis
15. Fibrositis is a psychogenic rheumatism, in which pain occurs over joints, ligaments, tendons, capsules and bursae. Usually there is a trigger point. Morning stiffness of short duration. Symptoms aggravated by fatigue, tension, immobility and cold, and ranges from mild to severe. Usually occurs in middle aged female with mild diabetes mellitus.

CONGESTIVE HEART FAILURE

1. Definition - inability of heart to pump adequate amount of blood in terms of venous return and metabolic needs of body

2. Afterload - impedence to ventric ejection or pressure ventricle must develop to pump; as afterload increases stroke volume decreases

3. Preload - VEDV
   Increased preload leads to increased stroke volume
   The more central the blood distribution the greater preload leads to increased stroke volume
   Peripheral blood pooling reduces preload

4. Compliance - relation between pressure and volume
   Hypertrophied ventricle is less compliant, small (increased volume results in elevated pressure)

5. What is underlying heart disease
   What is precipitating factor

6. Underlying causes
   1. increased afterload
      a. arterial hypertension is most common cause
      b. supravalvular aortic stenosis, coartaction of aorta
      c. valvular aortic stenosis
      d. subvalvular

   2. Increased preload
      aortic or mitral regurgitation
      pulmonic or tricuspid insufficiency

   3. decreased filling
      a. valvular stenosis
      b. pericardial constriction
      c. myocardial
      d. endocardial

   4. Ventricular aneurysm or dysynergy

   5. primary myocardial abnormalities
      cardiomyopathy
      myocarditis
      metabolic disease
      inadequate myocardium

   6. secondary myocardial dysfunction
      chronic increased afterload or preload
      ischemia
      shock
      drugs or toxins

7.

High output vs.	Low output failure
hyperthyroidism	Coronary artery disease
anemia	increased blood pressure
arteriovenous fistula	cardiomyopathies
beriberi	pericardial disease
Paget's disease	valvular disease
increased demand	decreased supply

8. Precipitating causes

1. increased metabolic needs
    - physical or emotional stress
    - pregnancy
    - infection
    - thyrotoxicosis
    - anemia
    - hypoxemia

2. acute myocardial dysfunction
    - ischemia
    - acute myocarditis

3. acute increased preload or afterload
    - infectious endocarditis
    - traumatic heart disease
    - prosthetic valve malfunction
    - acute ischemia
    - acute increased blood pressure
    - pulmonary embolus

4. arrhythmias
    - tachycardia
    - bradycardia
    - atrial dysfunction

5. Iatrogenic
    - dietary - increased Na+ intake
    - not taking Digoxin, diuretics and other antihypertensives
    - Thyroid drugs or anti depressants increase metabolic needs

8. Forward heart failure
increased blood value to increased preload

9. Compensatory mechanisms
a. sympathetic nervous stimulation
b. increased blood value 2^{o} renal fluid retention

10. Left sided failure
increased pulmonic venous pressure secondary to causes pulmonary fluid leading to decreased lung compliance and increased work of breathing

11. Left sided failure leads to right sided failure - backward failure

12. Symptoms of increased pulmonary venous pressure
    - a. dyspnea
    - b. orthopnea
    - c. paroxysmal nocturnal dyspnea
    - d. wheezing secondary to bronchospasm

13. Symptoms of increased systemic venous pressure
    - a. anorexia
    - b. nausea
    - c. right upper quadrant pain
    - d. edema

14. Physical findings
    - a. decreased cardiac output
        - 1. decreased pulse pressure
        - 2. cyanosis
        - 3. confusion
        - 4. Cheyne-Stokes respiration
        - 5. fatigue, weakness
    - b. decreased myocardial function
        - 1. S_3, S_4 gallops
        - 2. pulses alterna
        - 3. soft first heart sound
    - c. increased pulmonic venous pressure
        - 1. basilar rales
        - 2. wheezes
    - d. sympathetic stimulation
        - 1. tachycardia
        - 2. hypertension
        - 3. peripheral cyanosis, coldness, pallor
        - 4. diaphoresis
    - e. elevated systemic venous pressure
        - 1. neck vein distention
        - 2. hepatomegaly and dysfunction, hepatojugular reflux
        - 3. ascites
        - 4. edema
    - f. pleural effusion
        - 1. dullness to percussion
        - 2. decreased breath sounds
    - g. murmurs (mitral and tricuspid) may be secondary to papillary muscle dysfunction

15. Valuable studies
    Chest x-ray
    Arterial blood gases

16. X-ray changes
    cardiomegaly
    increased pulmonary vascular markings
    Kerley B-lines

17. Classification (New for Heart Association Classification)
    I - no symptoms
    II - symptomatic with ordinary activity
    III - symptomatic with less than ordinary activity
    IV - symptoms at rest

18. Therapy
    a. diuretics) decrease central blood volume
    b. vasodilators)
    c. digitalis
    d. correct precipitating cause
    e. oxygen
    f. correct underlying disease (if possible)

Introduction to Rheumatology

1. a) Study of diseases of joints or connective tissues
   b) Subjective complaints of joint pain
   c) Objective findings of inflammatory process occurring in joints

2. Two bones covered by articular cartilage
   May be intra-articular cartilage, a meniscus
   All enclosed in a fibrous capsule

3. a) Entire joint is lined by synovial membrane
   b) The membrane actively filters blood, producing a viscous fluid high in salts and low molecular weight proteins. The membrane produces hyaluronic acid and excretes it in the synovial fluid
   c) snyovial fluid is a lubricant

4. Any amount of aspirable synovial fluid indicates that some disease process is occurring

5. a) Osteoarthritis is due to wear and tear on joint surfaces. Adult cartilage is replaced by immature embryonic cartilage which is not as durable
   b) The bone tries to compensate for the joint instability by lipping. This eventually results in narrowing of joint space
   c) Synovial fluids shows no inflammatory characteristics

6. a) Here pathology starts in synovial membrane as a chronic inflammatory process. The synovial membrane proliferates, which enlarges the joint.
   b) process may occur in tendon sheaths or ligaments, weakening them and allowing for their rupture

7. a) The joint is hot, erythematous and swollen with decreased function
   b) Erosion of joint cartilage with cyst formation on x-ray

8.

Characteristics	Group I	Group II	Group III
color	yellow	cream	pus
clarity	clear	turbid	turbid
viscosity	high	decreased	increased
clotting	none	occasionally	yes
WBC	less than 1000	15,000	greater than 20,000
Percent Polys	greater than 25%	70%	90%

Group IV has blood in it
Traumatic tap-blood is in strings
Chronic inflammation-homogenous distribution of blood

Group I Diseases

Osteoarthritis
systemic lupus
rheumatic fever
sympathetic effusion
hypertrophic pulmonary osteoarthropathy
resolving group II

Group II

Rheumatoid arthritis
gout
pseudogout
Psoriatic arthritis
Reiter's syndrome
arthritis of ulcerative colitis,
regional enteritis
sarcoid
tuberculosis
rheumatic fever
lupus
resolving group III

Group III

Gonococcus
E. Coli
Pneumococcus
Staphylococcus
Streptococcus
Chronic renal failure
steroids

Bloody Fluid

Trauma
fractures
synovitis
metastatic tumor
hemorrhagic disease

Rheumatoid Arthritis

1) A disease of connective tissue in and around the joints, extra-articular inflammation may also occur.

2) The pathology involves hyperplasia of the synovial membrane, resulting in degeneration of cartilage through chronic inflammation.

3) Involvement of metacarpal carpal joint of thumb, any of the carpal bones of the wrist. The proximal interphalageal joint of the finger.

4) Morning stiffness lasting more than one hour
Fatigue
Night pain-upon sitting or retiring for the evening
Weakness possibly due to myositis
Joint pain

5) See 4 above
Characteristic pattern is morning stiffness, relief of stiffness later, recurrence of pain and stiffness in later evening

6) Joint swelling
Stiffness
Loss of motion

7) Females have disease twice as often as males
No racial preference
No climatic preference
Questionable increased occurrance in spring
No relationship to personality
Peak ages of occurrance are 35 and 45 years old. Also in elderly
onset may be acute or insidious.

8) Small joints of hand and wrist
Metacarpal phalangeal joints
Wrist, knees, toes
Subtalar and elbow areas
Temporal mandibular joint
Sternoclavicular and acromioclavicular joints
cervical spine (high incidence)
hip, joints (rare)
any joint or bursae

9) Nerve compression due to synovial hyperplasia
Laryngeal obstruction due to inflammation of cricoarytenoid joints
Anorexia
malaise
Anemia-failure to release RBC, not greater than 10 mg.%
Nodules-usually over pressure areas, also lungs, other organs

Pericarditis-frequent, but not clinically significant
Pulmonary fibrosis-not uncommon, mild to severe, may cause effusion
Vasculitis-at center of most nodules
Raynaud's phenomena
Neofuld thrombi with severe ulcers
Peripheral neuropathy
Lymphadonopathy

10) Felty's syndrome is hypersplenism with vasculitis
Sjogren's syndrome is absence of salivary secretions, lacrimal secretions, resulting in xerostomia, and keratoconjunctivitis sicca.

11) Leukocytosis of 10-15%
Rheumatoid factor

12) Place patient's serum in solution of latex particles coated with denatured gamma globulin. If agglutinate occurs then patient has factor that will agglutinate denatured gamma globulin.

Positive in 70-80% of people with rheumatoid arthritis need dilution greater than 1/80 since 5% of population is positive without disease

13) Early disease
No changes
Periarticular swelling
Osteoporosis- (local) to disease area
Slight narrowing joint space
Superficial erosion of cartilage

Late disease
Generalized osteoporosis
Erosin and pseudocyst
Marked joint space narrowing
Hypertrophy of bone

14) May cause sudden death by allowing spinal cord to be transected at C1 or C2 level.

15) Monoarticular-self limited, group II fluid, process usually resolves with or without therapy, may recur rarely

Adult onset type- 1 or 2 painful joints then more joint involvement, produces deformity, (progressive disorder).

Stills Disease. Inflammatory arthritis with transient skin reaction usually salmon pink, efferescent macular rash, hepatosplenomegaly, fever.

20

Other Inflamatory Types of Arthritis

1) Rheumatoid arthritis, gout, pseudogout, sarcoid, Reiter's syndrome, arthritis of inflamatory bowel disease, tuberculous arthritis, psoriatic arthritis and rheumatic arthritis.

2) a) asymmetrical arthritis
Involvement of distal interphalangeal joint and finger nail with psoriasis
b) Latex fixation usually negative except for 5% normally positive
c) exacerbations and remissions parallel psoriasis arthritis may precede psoriasis by several months

3) Subungal elevation, ridging and pitting of nails.

4) Focus of treatment is to improve psoriasis

5) Psoriatic arthritis presents asymmetrically, with psoriasis of skin and nails and negative latex fixation.

6) Arthritis, mucocutaneous lesions, conjunctivitis and urethritis or diarrhea.

7) Arthritis-acute periarticular swelling resulting in sausage-shaped finger.

Mucocutaneous lesion in mouth, on tongue or penis
Conjunctivitis mild, usually not noticed
Urethritis-whitish discharge
Diarrhea-may replace urethritis

8) Male disease, rare in female where diarrhea replaces urethritis

9) Young men, 18-30 years old

10) Involvement of sacroiliac joint in 100% of cases resulting in back pain.
Involvement of posterior epiphyseal joints results in decreased motion of spinal column.
Net result is straight lumbar region, and thoracic kyphosis.
Decreased chest expansion due to involvement of posterior costovertebral joints.
Peripheral joints involved are large ones, shoulders, hip, elbows, knees.

11) HLA-27, found in other arthritides involving sacroiliac joint.

12) May progress in time to a clinical picture much like rheumatoid arthritis.

13) a) Ulcerative colitis, regional enteritis, Whipple's disease, bowel disease; post bypass surgery.
b) Asymmetrical arthritis, may precede bowel disease
Group II fluid (if present at all)
arthritis parallels bowel disease

14) a) Syndrome resulting in proximal muscle stiffness in shoulders and pelvic girdle, upper arms and legs. No weakness is present.
b) Occurs in 50-60 year old population.
c) All lab values are negative except for elevated Westergren sedimentation rate, greater than 50 millimeters.

Elevated alpha 2 globin
Mild anemia (greater than 11 Gm% Hgb)
Muscle enzymes-SGOT, LDH, CPK and aldolase all normal
EMG normal
Biopsy muscle normal

15) Temporal arteritis

16) Signs and symptoms similar to polymyalgia rheumatica
Temporal artery should be biopsied.

J. M. Caplan

Antibiotic Prophylaxis

1. Antibiotic prophylaxis may be used to treat
    1. T.B.
    2. Rheumatic Fever
    3. Meningococcemia

2. Population at risk - limit patients you want to treat, enables you to treat prophylactically.

    Duration of risk - shorter periods of time are best for treating prophylactically

    Organisms involved - It is best to protect against only 1 or small number of organisms.

    Sensitivity to antibiotics 100% sensitivity to organisms involved

3. Population at risk for developing TB
    1. Children < 5 years old
    2. Adolescents

4. T.B. menigitis 79% of cases occur in children under 5

    Less than 1 yr. 19%
    1-2 yrs. old 43% > Total 79%
    3-4 yrs. old 17%

5. Isoniazid use when
    1. Patient is recent convertor and under age 30
    2. Patient is immunosuppressed and has a positive skin test

6. Patients with 1 episode of acute rheumatic fever have a 16% chance of having acute rheumatic fever recurr with another attack of streptococcal pharyngitis.

7. Patients developing streptococcal pharyngitis go on to rheumatic fever 1-3% of the time. Percentage greater in armed forces and less in communites.

8. Patients with 1 episode of ARF with carditis have a 60% chance of developing carditis in future attacks of ARF following streptococcal pharyngitis.

9. Recurrence of attacks of ARF occur within 4-5 years and majority occur within 2-3 years.

10. To prophylax again recurrence of ARF use:

    Benzathine Penicillin 1.2 x 10^6 units 1/month I.M.
    Penicillin P.O.
    Sulfa P.O.

11. Problems with oral penicillin
    36% poor compliance
    32% fair compliance
    32% good compliance

12. Meningoccemia prophylaxis
    1. 3.9% $<$ 15 years old with contact get disease
    2. Carrier role is 20-90%

13. Groups that should have prophylaxis
    1. Patients under 15 years old with history of contact
    2. Military population with contact

14. Sulfa drugs reduce carrier rates to almost 0% but 50% of strains are resistant to sulfadiazine. Penicillin reduces carrier rate only slightly.

15. Penicillin 1×10^6 units b.i.d. x 4 days
    1. drug of choice for menigoccemia
    2. little effect on carrier rate

16. Minocycline use will decrease incidence rate but patients develop labyrintitis, head spinning and inability to drive a car.

17. Four factors providing ideal situations for prophylaxis
    1. Population without underlylng risk
    2. Shortperiod of risk
    3. Single organism
    4. Universal sensitivity of organisms involved to drug that is well tolerated by patients.

7. Adrenal - hypertension
    cushings syndrome
    primary aldosteonism
    pheochromocytoma
    adrenogenital syndrome
        (11-B Hydroxylase & 17 hydroxylase defects)

Neurogenic Hypertension
   a. bulbar poliomyelitis
   b. cerebral hemorrhage, lead encephalopahty - rapidly rising intracranial pressure

Miscellaneous Hypertension
   a. coartation of the aorta
   b. contraceptive pills
   c. hypercalemia

8. Routine workup for hypertension
   History & Physical Examination, RUN, serum creatinine, Lytes, Urinalysis CBC,
   1. History of: Nervousness, palpitations, paroxysmal hypertension = suspect pheochromocytoma
   2. Hx. of long standing proteinuria suspect renal disease & 2^o hypertension,
   3. PE - bruit over flank - supect renal artery stenosis
      significant disparity of L & R arm pressure or decrease and/or absent femoral pulse suspect coartation of aorta
   4. BUN and creatine - high BUN and high serum creatine with mild hypertension - suspect renal parenchymal disease and 2^o hypertension - Mild hypertension does not cause renal parenchyma disease.
   5. lytes: decrease k+ - 1^o aldosteronism if no diuretics are being administered
   6. Urinalysis and CBC
   7. Blood glucose - r/o diabetic primary nephropathy
      Chest x-ray and EKG - to r/o hypertensive changes
      Hypertensive intravenous pyelogram

9. -HIVP - 1. recommended routinely by one group
   2. recommended for therapeutic patients and young patients, and patients with onset of hypertension at > 50 years
   23×10^6 Americans have high blood pressure and is too costly to do routinely

10. Characteristics of hypertensive IVP suggestive of renal artery stenosis
   (most renal artistenosis does not always produce hypertension)

IVP - delayed appearance of dye
   decreased renal length (1.5-2.0 cm)
   hyperconcentration and delayed disappearance of dye
   ureteral notching

Evaluation of Hypertension

Kwan E. Kim, M.D.

1. Pathogenesis of hypertension

   BP = CO x TPR

   Hypertension may result from

   a. ↑ CO2
   b. ↑ TPR
   c. or a combination of the two

   TPR $-\eta V/r^4$

   minimum changes in r will result in significant changes in BP

2. Two classes of hypertension:

   a. systolic hypertension
   b. systolic & diastolic hypertension

3. 1. primary hypertension of essential hypertension-no known causes
4. 2. secondary hypertension-according to organ systems which cause high blood pressure

   Renal hypertension
   adrenal hypertension
   neurogenic hypertension
   miscellaneous hypertension

5. Systolic hypertension determined by two factors

   a. ↑ stroke volume
      - thyrotoxicosis
      - anemia
      - heart block
      - arterio venous fistula

   b. ↓ compliance of the aorta & its large branches
      - arterosclerosis-most common cause of hypertension
      - high systolic pressure/normal diastolic pressure

6. Renal Hypertension

   a. renal parenchymal hypertension
      1. acute and chronic glomurolonephritis
      2. intestinal nephritis
      3. polycystic kidney disease
      4. radiation nephritis
      5. other renal parenchymal disease, lupus and diabetic nephropathy

   b. renovascular hypertension
      1. renal artery stenosis
      2. renal arteriovenous fistula
      3. aneurism of renal artery
         embolism of renal artery and infarction

11. Diagnostic tests for renal artery stenosis
    a. IVP
    b. renogram - high false positive results
    c. renal angiogram
    d. split renal function test
    e. peripheral renin and renal vein renin determinations

12. Most distinguishing sign of renal artery stenosis is
    a. high (renin) x 2 fold in affected kidney side
    b. peripheral renin

13. Renal A. stenosis does not always cause hypertension because contralateral kidney over compensates.

14. Ureter catheters are inserted into each ureter
    urine collected from each catheter
    renal function test, creatinine, pAH inulin clearance
    split renal function, Howard's test (1956)
    $\left.\begin{array}{l}\text{50\% or more reduction of urine volume}\\ \text{15\% or more reduction of urine Na+ concentration}\end{array}\right\} = \text{positive response}$

    Stamey's test (1961-1962)
    50% or more reduction of urine vol. urine PAH concentration increase in affected side than normal side - positive result

    Solutes not reabsorbed are high in affected side because this kidney has a high excessive water reabsorption. Increase in, and creatinine and PAH clearance

15. Causes of primary aldosteronism
    a. Adenoma 80%
    b. adrenal cortical hyperplasia 15%
    symptoms: muscle weakness, fatigue, polyuria, polydipsia, headache paresthesia, tetany, no edema, mild to moderate hypertension (no malignant hypertension)

    Clinical clues of primary aldosternoism
    1. Moderate hypertension
    2. weadkness
    3. polydipsia, polyuria
    Laboratory test: Hypokalemia, Metabolic alkalosis

16. Diagnostic modalities for primary aldosternoism
    1. low rein with stimulation
    2. High aldosterone secretion (with suppression with high Na+ diet & supine position)

    Adenoma - if removed hypertension is resolved -
    Nodular hypertension - gland is removed, hypertension persist, Rx medical, by (spiranolatome therapy)

1. Adrenal venography and split adrenal vein aldosterone blood drawn from right & left adrenal vein for aldosterone determination

2. Dr. Kahn reports that small adenomas can be identified by
   131, 1-19 lodo cholesterol adrenal scan

17. Renin is produced from JG cells.

18. Angiotensinogen (renin) subtrate antiotensin I conserting angiotensin II
    Angiotensin II - potent vasoconstrictor
    potent stimulator of aldosterone secretion

19. Pheochromocytoma
    associated diseases: neuro-fibromatosis, CNS hemangiotoma, parathyroid adenoma & medulary carcinoma of the thyroid with amyloid deposits, (sipple's syndrome) incidence of gall stones

Symptoms and signs:

1. paroxysmal hypertension
2. persistent hypertension
3. headache, excessive perspiration, palpitation, nervousness, due to excess catacholamines
4. postural hypotension

Laboratory

1. 24 hours urine collection for urinary VMA; free cateachotamine and metanephritis
2. Provacative tests: Histamine
   Tyramine
   Glucagon

Dr. Schelp Venereal Disease D. Pirozzi

1. Gonorrhea - most frequently reported communicable disease
   Syphilis - 4th most frequently reported

2. Syphilis - age 15-29 most often affected

3. Syphilis caused by Treponema Pallidum

4. Long acting penicillin is treatment for syphilis because the organism divides by binary fission and takes a long time

5. Characteristic lesions in males with syphilis
   1. Punched out papule
   2. Ulcer with a hard, round border, escavated below surface "Huntarian chancre"
   3. Friable lesion (bleed easily)

6. Characteristic lesions seen in females with syphilis
   1. Occurs on exterior parts - similar to male
   2. Punched out papule. Ulcer with hard, round border

   Difficult to make diagnosis in females because lesion can occur on cervix and may be missed upon examination

   Primary lesions are painless

7. Autoinocculation because of the proximity of certain mucous membranes (labia majora for example) syphilis may appear in one part as a primary lesion and spread to another part as a primary lesion by direct contact.

8. Incubation period for syphilis is 10-90 days in primary form.

9. Characteristics of lymphadenitis related to syphilis
   1. Unilateral or bilateral
   2. Enlarged nodes
   3. Not painful unless secondarily infected

10. Secondary syphilis arises 6-8 weeks after primary lesion which is untreated occurs.

11. Manifestations of secondary Syphilis
    1. Papulo - squamous lesions occuring all over the body

12. Spirochietemia is the appearance of T. Pallidum in the blood streat with distributed throughout the body. This is secondary syphilis

13. Dark field microscopy will reveal organisms that are scraped from lesions

14. Nickel dime lesions are secondary lesions located on the face. Lesions are: 1. like vasculitis 2. Dark center with round and heaped border

15. Scalp hair in a patient with secondary syphilis may show moth-eaten alopecia (loss of hair)

16. Tertiary or late syphilis will occur 2-10-20 years after initial contact with disease providing the disease has not been treated.

17. Early latent syphilis - untreated syphilis of under 2 years duration

Late latent syphilis - untreated syphilis of over 2 years duration with a negative spinal tap (negative serologic testing tap).

18. Sequelae of late latent syphilis
    1. Gumma

19. Gumma - scaring lesions thought to be an allergic reaction against the untreated syphilis. Scaring lesions thought to be an allergic reaction against the untreated syphilis. Scars in center and grows in periphery.

20. Gumma characteristics
    1. Occur in liver, bone, brain

21. Late syphilis may develop
    1. Aneurysms of ascending aorta
    2. Neurotrophic ulcers in feet

22. Factors in screening patients with positive serologic results indicating primary syphilis
    1. 85% of patients with positive FTA - ABS - 15% negative
    2. 78-80% of patients with primary syphilis will have positive VDRL
    Not all patients with primary syphilis will have reactive tests upon routinely testing.

23. All lesions of late syphilis do not always occur in all patients with untreated syphilis

24. In untreated secondary syphilis serologic test results are 100%

25. In tertiary syphilis one must use treponemal test
    1. FTA-ABS
    2. TPI

26. Morphologic movements of Treponema Pallidum
    1. Spiral on own axis
    2. Moves forward
    3. Flaps in middle

27. Treatment Protocol
    1. Benzathine penicillin 2.4 x 10^6 u at one sitting for primary and uncomplicated secondary syphilis as well as tertiary syphilis with negative spinal tap - same for male and female
    2. Late syphilis with symptoms or positive spinal tap 6-9x10^6u benazathine penicillin in 3 weeks. Usually 2.4 x 10^6 at first sitting I.M. followed by same dose for next 2 weeks

28. Alternative drugs
    1. Procaine penicillin
    2. Aqueous penicillin
    3. Tetracycline } if allergic to penicillin
    4. Erythromycin

29. Age range for gonorrhea 15=29 years

30. Incubation period for gonorrhea 3-5 days

31. Gonorrhea harder to control than syphilis because of short incubation period it spreads faster and is harder to stop.

32. Organism responsible for Neissaria Gonorrhea

33. Manifestations of gonorrhea in male and
    1. Urethral discharge - cloudy white
    2. Difficulty urinating ♂
    3. Frequency

34. Gonorrhea may be asymptomatic in female

35. Gram stain criteria for diagnosis in male
    1. Gram -
    2. Diplocci
    3. intracellar

36. Culture in male necessary if disease is suspected but not found in the smear: Culture in transgrow of Thayr Martin

37. Many organisms have a similar gram stain as N. Gonorrhea on the cervical smear. Therefore culture is necessary

38. Steps and 3 criteria for positive diagnosis of gonorrhea
    1. typical colonial morphologh - small, white
    2. Oxidase positive colonies - black color
    3. Gram negative ciplococci

39. For definitely positive cultural diagnosis
    1. Sugar fermentation reaction
    2. Direct florescent antibody staining

40.

Neisseria Gonorrhea	Neisseria Menigitis
Ferments	Ferments
+glucose	+glucose
-maltose	-maltose
-sucrose	-sucrose

41. Complications of gonorrhea
    1. P.I.D. (Pelvic inflammatory disease)
    2. Sterility
    3. Involvement of sexual organs
    4. Menigitis
    5. Conjunctivitis
    6. Myocarditis
    7. Pericarditis
    8. Endocarditis
    9. Proctitis
    10. Skin eruption - popaules→ pustules→ vesicles
    11. Arthritis

42. Protocol for treating uncomplicated gonorrhea in male and female urethral, cervical, pharyngeal, rectal
    1. I.M. aqueous procaine penicillin 4.8 x 10^6u (2.4 in each buttock)
       1 gram oral probenecid 30 minutes prior to I.M. penicillin

43. If I.M. injection is not tolerated use oral ampicillin 3.4 grams (1 dose) plus 1 gram orally administered probenecid

44. Asymptomatic partners receive identical treatment

45. If allergic to penicillin
    Males
    1. Spectinomycin 2 gram 1 I.M. injection
    2. Tetracycline
    Females
    1. Spectinomycin 4 gm. I.M. injection
    2. Tetracycline - 1.5 gm. initially followed by 500 mg. q.i.d.
       till total of 9.5 grams

46. One week after treatment

47. Test for cure includes
    1. Cervix and rectum recultured
    2. Gram stain

48. Chancroid - sexually transmitted venereal disease caused by hemophilus ducrliyi incubation period 2-5 days.

49. Location and characteristics of lesion
    1. Shallow, painful, soft, dirty ulcer
    2. Multiple lesions common
    3. Regional lymphadenitis

50. Testing protocol
    1. clinical appearance
    2. negative darkfield
    3. negative serology

51. Dark field examination must be made to differentiate chancroid from syphilis

52. Treatment protocol for chancroid
    1. Sulfanamides 1-3 week
       Gantricin 4 grams a day till remission

53. Use of tetracyclines will mask the possibility of coexisting syphilis

54. Lymphogranuloma venereum
    1. etiology chalamydia
    2. evanescent painless vesicle or papule healing 1-2 days after arising
    3. incubation 3-7 days
    4. Bubos (lymphadenitis) appear in male 10-30 days after initial lesions, also proctitis and rectal stricture in female

55. Diagnosis: by clinical appearance
Frei test - antigen of etiologic agent placed on one arm and control on other arm. In 48 hours read and if antigen site is larger than control site make presumptive diagnosis remains positive for years - so must use another test for diagnosing reinfection
Complement fixation test may be used.

56. Treatment protocol
    1. Sulfonamides
       Gantrisin 4 gram day till remission
       Tetracycline 2-4 grams day till remission
       Untreated lesions may lead to bubos in 10-30 days (lymphadenitis)

57. Lymphogranuloma venerum in female may lead to rectal strictures and then to rectal cancer

58. Lymphogranuloma inguinale
    1. etiology: donovan body
    2. insidious onset, painless papule or nodule erodes to leave beefy red, granular base
    3. pseudobubos may be present
    4. No true lymphadenitis without secondary infection
    5. Incubation 1 week to 8 days

59. Lesions of lymphogranuloma inguinale
    1. painless papule or nodule eroding to leave beefy red, granular base

60. Differentiate lymphogranuloma inguinale from syphilis
    1. Donovan bodies in scraping
    2. Negative dark field and serology

61. Herpes simplex
    1. Etiology - herpes simplex virus
    2. Begins with tingling or pain developing into grouped vesicles upon affected organ. These ulcerate and then heal without scaring.

62. Herpes simplex lesion - grouped, painful, vesicular lesions with erythematous base.

63. Diagnosing Herpes simplex
    1. Giemsa stain of scrapping of vesicle base one sees multinucleated giant cells.
    2. Viral culture difficult
    3. Negative serologic testing

64. Treatment of herpes simplex
    1. local measures to dry up vesicles
    2. Biologic dyes and fluorescent lamp to kill virus and hasten healing

65. Venereal Warts - condyloma accuminata etiology papova virus

66. Characteristics of venereal warts
    1. begin as small papular lesions at site of innoculation and proliferate into tumors
    2. grow on cervix, labia majora, vagina or penis
    3. diagnosis made by clinical appearance
    4. diagnosis made by ruling out syphilis

67. Podophyllin is a mitotic inhibitor and will inhibit growth of rapidly proliferating veneral warts.

ISCHEMIC HEART DISEASE (I.H.D.)

1. Inadequate perfusion of a portion of the myocardium, so that O_2 need of that portion of the myocardium becomes greater than its supply
2. Coronary artery disease (CAD) is a cause of IHD
3. Anemia, hypertension, CAD, other hemodynamic abnormalities
4. Arteritis, embolisation, collagen diseases, infections or rheumatic processes
5 Within 4 cm of the coronary ostia
6. lipids, complex carbohydrates, blood, blood products
7. Contractile state of the myocardiu, heart rate, wall tension, left ventricular pressure, ventricular volume
8. Aortic pressure, coronary vascular resistance, coronary blood flow, distribution between epi and endocardium, arterio-venous O_2 difference
9. Modifiable; hypertension, hypercholesterolemia, hypertriglycemidemia, cigarette smoking, physical inactivity, obesity, emotional stress
   Unmodificable: sex, heredity, diabetes mellitus
10. Maintain ideal weight, maintain normal blood pressure, stop cigarrette smoking
11. Anterior chest wall pain brought on by exertion and relieved by rest on NTG
12 .ST segment depression, or elevation; arrhythmias
13. Anerobic metabolism, production of lactic acid, because heart can no longer maintain normal metabolic pathways
14. The blood supply is no longer adequate
15. Akinesia - no contraction in the area of heart muscle not getting enough blood supply
    Dyskinesia - an area of heart muscle which doesn't contract and paradoxically moves in the opposite direction -(aneurysmal movement)
    Hypokinesia
16. Hiatal hernia, gall bladder disease; upper GI problems, neck disease, chest wall syndromes
17. Whether there is an obstruction of C.A.D., However, if C.A.D. or obstruction is found it may not be the cause of pain
18. Chest pain is worse than anginal pain, not influenced by NTG or rest, sweating, belching, feeling of tremulousness and fear, arrhythmias
19. Atrial fibrilation, ventricular tachycardia, ventricular fibrilation

ABNORMALITIES IN URINE EXAM

1. a. chemical & physical properties
   b. protein
   c. sediment

2. a. specific gravity
   b. osmolality
   c. lytes Na+, k, Cl⁻
   d. urine urea nigrogen
   e. urine creatinine

3. 2nd

4.

Dehydration	Mechanism
urine Na < 10 meq.lL	↑ aldosterone effect
urine K > 40 meq. lL	↑ aldosterone with hypovolemia
urine 5.6 ↑ > 1.020	↑ solute ↓ urine vol.
urine Osm ↑ > 1.5 x Plasma Osm	↑ #particles in solution
urine Urea ↑ > 300 mg.% > 10 x BUN	small vol. large solute
urine Creatinine 7150 mg% > 20 x serum creatinine	small vol. large solute

Acute tubular necrosis	
urine Na+ > 40 meq lL	renal tubules can't conserve Na
urine K+ < 40 meq lL	no exchange for Na
urine S.G ↓ 1.008 → 1.014	can't concentrate actively
urine Osm low ~ 1:1 with Osm plasma	can't concentrate actively
urine Urea ↓ < 300 mg% 200 mg% < 10 x BUN	"
urine Creat ↓ 10 x (creat) serum	"

5. a. dip stick 15 mg% - (less sensitive)
   b. sulfosalicylic acid 10 mg%

6. Overhydration leads to ↑ volume and urine protein will decrease, may miss thin protein concentration on dip stick

7. Urinary protein excretion. Creatinine excretion per 24 hours. Evaluate muscle mass and adjust urinary protein excretion value to correspond with estimated creatinine excretion to tell how much of 24 hour collection was deleted

8.

Normal	< 50 mg to 100 mg	protein in urine/24 hours
mild	100-500 mg	" " " " "
moderate	500-2000 mg.	" " " " "
severe	> 2000 mg.	" " " " "
nephrotic	> 3500 mg.	" " " " "

9. a. no over hydration
   b. no unusual increase in activity

10.

Fixed proteinuria	+	Orthostatic proteinuria
reproduce able in all positions		Upright aetive proteinuria

< 500 mg. 124 hr. (95%)
< 50 mg. during supine posture for 12 hours
> 100 mg. during active-upright posture for 12 hours

11. Not related to any specific disease

12. Perisitent proteinuria

13.

Acute tubular necrosis (ATN)	Acute interstial nephritis (AIN)
a. renal tubular epithelial cells case	a. tubular epithelial cells
b. numerous tubular epithelial cells	b. increase in WBC
c. pigmented granular casts	c. WBC cast
	d. tubular epithelial cell casts

Acute glomerulonephritis	Acute pyelonephritis
a. RBC casts	a. increased WBC's
	b. increased WBC casts

14.

Cast In urine	Significance
RBC casts	glomerulopathy
Hyaline cast	with exercise & dehydration or diseas
Hyaline & Waxy cast	not patho gnomonic
granular cast	parenchymal disease
maltese cross	possible nephrotic syndrome
pyelonephritis (PMC & bacteria	acute pyelonephritis
telescopic casts	parenchymal disease active
epithlial cells	ATN, AIN
sodium urate crystal	gout, hyperuricemia

APPROACH TO PATIENT WITH INFECTIOUS DISEASE

1. Pain
   Swelling
   Redness
   Heat
   Loss of function
   Increase of body temperature
   Headache
   Chills
   Feverishness
   Rigor
   Malaise
   Arthralgia
   Lassitude
   Anorexia
   Sweats
   Weight loss
   Myalgia

2. Eruption (rash)
   Bleeding
   Cough
   Expectoration
   Diarrhea
   Frequency of micturition
   Discharge
   Adenopathy
   Visceromegaly

3. Infection
   Neoplasm
   Trauma
   Lymphoproliferative disorders
   Myeloproliferative disorders
   Metabolic = thyroid adrenal disease
   Vascular insufficiency
   Vascular occlusion
   Drug fever
   Collagen - vascular disease
   Hemolysis

4. Drug use leads to:

   1. allergies
   2. impurities causing fever
   3. drug - introduced infections
   4. adverse drug reactions

5. Hepatitis
   Staphylococcal
   Fungal endocarditis
   Malaria

6. Travel history - rapid transportation contact with disease
   ex: malarial contact
   coccidiomyocosis
   time: preceding 24-36 months

7. Occupation may relate to disease causing infection

8. Ex: meat packer - brucellosis
   gelatin firm (bone meal) - anthrax
   dairy - anthrax, Q fever, brucellosis, tularemia

9. Environment
   ets:
   Cats - Toxoplasmosis
   Turtles - Salmonella
   Dog Bite - Menigitis
   Bat & Raccoon -rabies

   Hobbies: caves - rabies
   Camping: Rabbit skinning - tuleremia
   Southwest USA plague

10. Drug, travel, occupational, pets, hobbies, contacts and immunizations history of disease

11. Daily exposure to a disease may dispose you to acquire disease

12. Similar symptoms in other persons suggest group infections and etiologic diagnosis

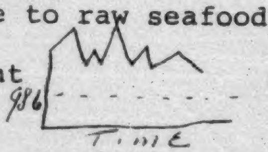
13. Bacterial food poisoning

14. 24-36 months if necessary

15. Partial immunizations may not protect from disease

16. Exposure to raw seafood (water born disease), raw meats

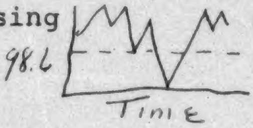
17. Remittent



spikes without return to normal

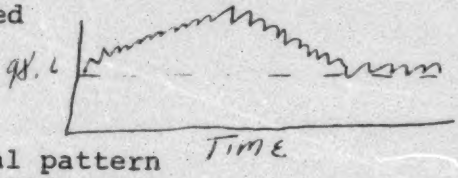
Not characteristic - may be infections

18. Relapsing



spikes with some lower than normal. Causes:
malaria, rat bite fever, relapsing fever
lymphocytic choriomeningitis, rickettsiosis,
charcotts intermittent
fever: biliary obstruction, UTI, Hodgkins:
Pel-epstein type of fever

19. Sustained



typhoidal pattern
Hepatobilliary disease

APPROACHES TO ANTIMICROBIAL CHEMOTHERAPY

1. a. Determine if infection is present
   b. Identify pathogen and sensitivity

2. Infection
   a. Signs of inflammation
   b. Symptomatology
   c. Epidemiology
   d. Lab studies

   Bacterial culture

3. Culture before chemotherapy

4. Cultures obtained after chemotherapy will grow organisms less frequently and identification will be more difficult

5. Gram stain gives resonable identification of organism and will help in choice of chemotherapy

6. 1. identify organism - presumptive
   2. rapid feedback
   3. accurate
   4. determine adequacy of specimen

7. Sputum

   1. PMN - Pus
   2. Predominant organism
   3. Types of epithelial cells present

8. 1. Determine causative agent
   2. Determine sensitivities
   3. Use narrowest spectrum entimicrobial agent

9. Broad spectrum antibiotic will alter (reduce) normal body flora which supply some essential nutrients and can lead to superinfection

10. By suppressing normal flora pathogenic bacteria may proliferate Since normal flora and pathogens compete for space and nutrients broad spectrum antibiotics lead to super infection

11. Lowest effective dose of antibiotic kills pathogen and alters normal flora the least. Depends upon:

    1. Microbe involved
    2. Body site involved
    3. Route of administration

12. Time of suppression should be short to minimally suppress normal flora

13. Streptoccocal pharyngitis - treat for 10 days. bacterial endocarditis treat for 4-6 weeks

14. Clinical judgement determine length of treatment. Normally therapytil 3-4 days after patient returns to good health will be adequate lenghth of treatment

15. New organism on follow-up culture indicates colonization by new microflora

16. Gram stain and culture of superinfection yield increased pus and overwhelming numbers of new organism.

17. Criteria for change of therapy

    1. failure of response after 3-5 days of therapy
    2. Lab reported resistance with failure of response
    3. Narrower spectrum drug available

18. MIC or MBC
    1. tube dilution sensitivity for antibiotic effectiveness serial dilution against cultures to determine effective antibiotic dose (in excess of 1:8 dilution) must inhibit bacterial growth of serum under study

19. MIC correlates with
    1. efficacy of chemotherapy
    2. efficacy of dose and route of administration
    3. correlates with survival

Bactericidal - lead to rupture & lysis and death of bacteria act on cell walls
Bacteristatic - lead to inhibition of bacterial growth, affect metabolic cell processes

20.

Bactercidal - more potent	Bacteristatic - less potent
Penicillins	Tetracyclines
Cephalosporins	Aminoglycosides
Amino glycosides	Lincomycin
Poly myxins	Chloranphenical
Anphotericin B	Macrolides
Nystatin	

21. Mixing bactericidal and bacteristatic agents is antagonistic and should be avoided. Bacteristatic agents inhibit protein synthesis and so bactercidal agents affecting; cell walls will be useless. Cell must be multiplying for factercidal drugs to be effective

22.

Gram +	Gram -
I Penicillin	I Cephalosporins
Methicillin	Ampicillin
Macrolides	Carbenicillin
Lincomycins	Aminglycosides
Vancomycin	Polymixins

II Cephalosporins
Tetracyclines
Choloramphenical
Sulfaoamides
A Aminoglycosides

II Tetracyclines
Chloramphenical
Sulfonamides
Rifampin

23. Gram +

Penicillin - narrow spectrum, safe, inexpensive, non-toxic

Methicillin - use if penicillianse producing staph is the organism narrow spectrum

Macrolides - use if patient allergic to penicillin and has gram + infection. Safe, narrow spectrum

Lincomycins - toxic, narrow spectrum use for staph

Vancomycin - use with staph resistance to penicillin, methicillin and cephalosporins

Cephalosporins - if parenteral therapy is required or patient is allergic to penicillin or for unknown sepsis

Tetracycline - Group A strep, staph and pneumococci have some resistance use for UTI or rickettsial or gram - organisms

Chloramphenical - limited spectrum

Sulfonamides - UTI, limited spectrum

Aminoglycosides - limited to staph (Don't use for systemic infections without trying penicillin)

GRAM - efficient must give parenterally

Cephalosporins: cidal, broad spectrum, safe

Ampicillin - narrower spectrum than cephalosporins, not the antibiotic of choice for gram +

Carbenicillin - potent, safe, restrict to pseudemonas, indol positive proteins and seracia

Polymyxins - toxic - use if organism resistant to cephalosporins

Chlorampehnical - UTI, use with anaerobic supporative processes below diaphragm and from female genitalia

Sulfonamides - UTI

Rifampin

24. Do not use for viral infections until after a bacterial infection is manifested

ANEMIA

1. Anemias characterized by increased MCV, and MCH, but normal MCHC and too few cells

2. Ovalomacrocytic - distinct o void RBC
   Polychromatophilic macrocytosis - bluish tinged and round RBC,
   Reticulocytes

3. a. Ovalomacrocytic: oval cells, aniso cytosis, larger than normal RBC, poikilo cytosis

4. Ovalocytes are large mature RBC with an oval shape on peripheral smear

5. Megaloblastosis, larger than normal cells, differences in nuclear and cytoplasmic maturation due to megaloblastic marrow activity

6. Normal: dark RBC precursors, pyknotic nuclei
   Megaloblastic: RBC precursors larger with larger nuclei, look at chromatin in nuclei

7. RBC are reticulocytes, bone marrow is normal

8. The altered DNA/RNA ratio is due to relatively suppressed DNA synthesis, cell division is impaired but protein synthesis continues

9. For some reason cells die in the marros - intramedullary cell death
   Total erythropoeitic capacity of marrow is not translated into effective delivery of cells into circulation

10. Marrow activity is increased but there is pancytopenia in the peripheral blood

11. Suppressed DNA synthesis with relatively unsuppressed RNA synthese so cells do not divide as much and because of intramedullary cell death

12. The cell did not divide as often as they should have

13. Pancytopenia in peripheral blood, Hypersegmentation of polymorphonclear

14. Vitamin B_{12} deficiency or folate deficiency

15. Cancer chemotherapy, some leukemias, some hereditary enzyme deficiences of nucleic acid metabolism

16. Discovery and characterize the anemia, define pathogensis, discover etiolo

17. No

18. Minimum daily requirement for Vit. B_{12} 1½-2½ micrograms/day

19. Intrinsic factor (glycoprotein) is secreted from parietal cells in stomach binds to Vit B_{12} and is absorbed in the terminal ileum, carried in the blood by the protein transcobalamin

20. 400 picograms/ml of plasma - range 200-1000 picograms/ml of plasma

21. Folic acid is sensitive to cooking and heating. Exists as complex in natures; polyglutamated folic acid. Glutamate is digested off in gut Absorbed mainly in jejunun and duodenual and thru-out entire bowel. Active form is tetrahydrofolic acid (THFA)

22. Minimum daily requirement 50mg/day

23. Vitamin B_{12} stores must be reduced to 10% of normal-about 500mg left (4500 mg/lost) with loss of 2 mg/day, it requires 7 years to become deficient

24. Vitamin B_{12} can be salvaged thru enterohepatic circulation. There is only a 120 day' s store of folate

25. Less time needed to develop folic acid deficiency

26. High LDH, greater than 2000. Out of proportion to clinical setting

27. Subacute combined degeneration of the spinal cord. Abnormal gait and Romberg's sign

28. Pregnancy increases the need for folate. Anticonvulsant drugs interfere with absorption of food folate.

29. Elderly patient with severe anemia, pancytopenia, ↑ LDH, neurologic symptoms. Failure to secrete intrinsic factor secondary to total gastric atrophy

30. Because stomach is atrophic in pernicious anemia, if acid is present pernicious anemia is ruled out; the converse is not true - iron deficiency, etc. can cause loss of audity without loss of intrinsic factors.

31. Send serum "Vit B12" and folate levels - takes several days to come back

32. Histidine is metabolized to form amino glutamic acid. The active form of folate degrades FIGLU to one carbon fragment. Give histidine at dinner and collect two six-hour urine specimens. Presence of absence of FIGLU is determined by electro phoresis

33. FIGLU present (positive test) THFA is absent or its activity is interfered with. This is not diagnostic of folate def. since Vit.B_{12} def. or drugs can also interfere with it. FIGLU absent: folate activity is normal or adequate

34. Therapeutic trial with small physiologic doses of Vit B_{12} or folate. Follow the retic count; if anemia is due to these deficiences it should rise within 3-7 days.

35. Give radioactive Vit B_{12} by mouth (1m g.) One hour later inject "cold" B_{12} (1000mg) to saturate transcolbalamin, collect 24 hour urine Vit B_{12} neither excreted nor resorbed in renal tubules

36. How much is absorbed in gut

37. Low radioactive Vit.B$_{12}$ excretion indicates
    1. Lack of intrinsic factor;
    2. Bowel not working
    3. Technical problems - i.e. patient vomitted or had diarrhea
       You must repeat the test

38. If excretion becomes normal, the patient lacks intrinsic factor - secondary to gastri atrophy (pernicious anemia) or gastrectomy
    If excretion remains low, the gastrointestinal tract is diseased

40. Alchoholism, drugs, malabsorption syndromes

41. Hemolytic anemia; shortened RBC survival

42. The bone marrow increases its output by increasing the number of cells committed to erythropoesis or it may shorten time for RBC to develop and be delivered. MASS of marrow increases and it can produce up to six times normal number of red

43. RBC survival is shortened but the patient is not anemic because marrow is keeping up with the increased destruction

44. Hgb is degraded into iron, globin and prophyrin which is metabolized to bilirubin, Iron and globin are reused

45. Jaundice would occur if the Hgb load is too great for liver to handle or if liver is diseased

46. Reticulocytes are larger than mature cells

47. Marrow failure with ehmolysis. Bilirubin increases; the reticulocyte count falls, and anemia develops

49. Congenital and acquired

50. Hereditary spherocytosis, hemoglobinopathies, thalassemias, elliptocytosis nonspherocytic hemolytic anemias

51. Non-immune or immune
    Immune: positive direct Coombs test

52. Cold antibodies give rise to cold agglutinins a symptom of cold intoleranc
    Warm antibodies, sensitize RBC to phagocytosis better and lead to more severe anemia and easy to see hemolytic processes

53. There are antibodies on the patient's RBC's

54. Bleeding

55. Ruptered ectopic prenancy and gastrointestinal bleeding

56. Anemias of marrow failure, indices within normal (maybe low MCHC)
Low retic count

57. Chronic disease (rarely) primary aplastic anemia

58. Inflammation; lack of response to erythropoeitin

59. Understand pathogenesis and etiology of anemia

Evaluation of Hypertension Kwan E. Kim, M.D.

1. Pathogenesis of hypertension
   $BP = CO \times TPR$

   Hypertension may result from
   a. ↑ CO2
   b. ↑ TPR
   c. or a combination of the two
   $TPR - \eta V/r^4$
   minimum changes in r will result in significant changes in BP

2. Two classes of hypertension;

   a. systolic hypertension
   b. systolic & diastolic hypertension
3. 1. primary hypertension of essential hypertension-no known causes
4. 2. secondary hypertension-according to organ systems which cause high blood pressure

   Renal hypertension
   adrenal hypertension
   neurogenic hypertension
   miscellaneous hypertension

5. Systolic hypertension determined by two factors

   a. ↑ stroke volume
      thyrotoxicosis
      anemia
      heart block
      arterio venous fistula
   b. ↓ compliance of the aorta & its large branches
      arterosclerosis-most common cause of hypertension
      high systolic pressure/normal diastolic pressure

6. Renal Hypertension
   a. renal parenchymal hypertension
      1. acute and chronic glomurolonephritis
      2. intestinal nephritis
      3. polycystic kidney disease
      4. radiation nephritis
      5. other renal parenchymal disease, lupus and diabetic nephropathy
   b. renovascular hypertension
      1. renal artery stenosis
      2. renal arteriovenous fistula
      3. aneurism of renal artery
         embolism of renal artery and infarction

7. Adrenal - hypertension
   - cushings syndrome
   - primary aldosteonism
   - pheochromocytoma
   - adrenogenital syndrome
     (11-B Hydroxylase & 17 hydroxylase defects)

Neurogenic Hypertension
   a. bulbar poliomyelitis
   b. cerebral hemorrhage, lead encephalopathy - rapidly rising intracranial pressure

Miscellaneous Hypertension
   a. coartation of the aorta
   b. contraceptive pills
   c. hypercalemia

8. Routine workup for hypertension
   History & Physical Examination, RUN, serum creatinine, Lytes, Urinalysis CBC,
   1. History of: Nervousness, palpitations, paroxysmal hypertension = suspect pheochromocytoma
   2. Hx. of long standing proteinuria suspect renal disease & 2° hypertension,
   3. PE - bruit over flank - supect renal artery stenosis
      significant disparity of L & R arm pressure or decrease and/or absent femoral pulse suspect coartation of aorta
   4. BUN and creatine - high BUN and high serum creatine with mild hypertension - suspect renal parenchymal disease and 2° hypertension - Mild hypertension does not cause renal parenchyma disease.
   5. lytes: decrease k+ - 1° aldosteronism if no diuretics are being administered
   6. Urinalysis and CBC
   7. Blood glucose - r/o diabetic primary nephropathy
      Chest x-ray and EKG - to r/o hypertensive changes
      Hypertensive intravenous pyelogram

9. -HIVP - 1. recommended routinely by one group
   2. recommended for therapeutic patients and young patients, and patients with onset of hypertension at > 50 years
   23 x 10^6 Americans have high blood pressure and is too costly to do routinely

10. Characteristics of hypertensive IVP suggestive of renal artery stenosis (most renal artistenosis does not always produce hypertension)

IVP - delayed appearance of dye
   decreased renal length (1.5-2.0 cm)
   hyperconcentration and delayed disappearance of dye
   ureteral notching

3

11. Diagnostic tests for renal artery stenosis
    a. IVP
    b. renogram - high false positive results
    c. renal angiogram
    d. split renal function test
    e. peripheral renin and renal vein renin determinations

12. Most distinguishing sign of renal artery stenosis is
    a. high (renin) x 2 fold in affected kidney side
    b. peripheral renin

13. Renal A. stenosis does not always cause hypertension because contralateral kidney over compensates.

14. Ureter catheters are inserted into each ureter
    urine collected from each catheter
    renal function test, creatinine, pAH insulin clearance
    split renal function, Howard's test (1956)
    $\left.\begin{array}{l}\text{50\% or more reduction of urine volume}\\ \text{15\% or more reduction of urine Na+ concentration}\end{array}\right\} =$ positive response

    Stamey's test (1961-1962)
    50% or more reduction of urine vol. urine PAH concentration increase in affected side than normal side - positive result

    Solutes not reabsorbed are high in affected side because this kidney has a high excessive water reabsorption. Increase in, and creatinine and PAH clearance

15. Causes of primary aldosteronism
    a. Adenoma 80%
    b. adrenal cortical hyperplasia 15%
    symptoms: muscle weakness, fatigue, polyuria, polydipsia, headache paresthesia, tetany, no edema, mild to moderate hypertension
    (no malignant hypertension)

    Clinical clues of primary aldosternoism
    1. Moderate hypertension
    2. weakness
    3. polydipsia, polyuria
    Laboratory test: Hypokalemia, Metabolic alkalosis

16. Diagnostic modalities for primary aldosternoism
    1. low rein with stimulation
    2. High aldosterone secretion (with suppression with high Na+ diet & supine position)

    Adenoma - if removed hypertension is resolved -
    Nodular hypertension - gland is removed, hypertension persist, Rx medical, by (spiranolatome therapy)

1. Adrenal venography and split adrenal vein aldosterone blood drawn from right & left adrenal vein for aldosterone determination

2. Dr. Kahn reports that small adenomas can be identified by 131, 1-19 Iodo cholesterol adrenal scan

17. Renin is produced from JG cells.

18. Angiotensinogen (renin) subtrate antiotensin I conserting angiotensin II
    Angiotensin II - potent vasoconstrictor
    potent stimulator of aldosterone secretion

19. Pheochromocytoma
  associated diseases: neuro-fibromatosis, CNS hemangiotoma, parathyroid adenoma & medulary carcinoma of the thyroid with amyloid deposits, (sipple's syndrome) incidence of gall stones

Symptoms and signs:
1. paroxysmal hypertension
2. persistent hypertension
3. headache, excessive perspiration, palpitation, nervousness, due to excess catacholamines
4. postural hypotension

Laboratory
1. 24 hours urine collection for urinary VMA; free cateachotamine and metanephritis
2. Provacative tests: Histamine
   Tyramine
   Glucagon

MENINGITIS

1) Signs and symptoms often subtle especially in children and elderly patients: Disturbed behavior, irritability, disturbances in consciousness; may resemble acute stroke, cerebrovascular accidents or focal neurologic disease.

Classically, fever, sepsis, with body temperature, paralleling that of room, headache, alterations of consciousness, obtundation, rigid hyperextension of spine.

2) Stiff neck due to nerve irritation resulting in increased muscle tone; May extend to lower spine resulting in pain on straight leg extension.

3)	Bacterial:	TB-Fungal:	Viral:
Cells --	Increased	Increased	Increased
PMN --	Increased	Increased	Increased
Lymph --	Increased	Increased	Increased
Protein --	Increased	Increased	Increaded
Sugar --	Decreased	Decreased	Increased

4) Fever, altered behavior.

5) Peripheral Blood Sugar/Cerebrospinal Blood Sugar 60% normally.

6) Gram stain of CSF.

7) Diplococcus, N. Meningococcus, H. Influenzue

8) H. Influenza 3 months to 3 years-old.
Diplococcus - most common early life, but present all ages -- adult and elderly.

N. Meningococcus occasionally less than 1-year-old, usually 2-years-old to adulthood.

9) Contiguous spread, bacteremia, otitis media, skull fractures, sinusitis, pulmonary disease, diabetes mellitus, alcohol, immunosuppression.

10) Usually due to cerebrospinal fluid leak most likely from cerebriform plate -- requires surgical repair.

11) Gives rise to super infection resulting in increased mortality.

12) Macular, papular, pustular rash or skin infarction with necrosis.

13) Waterhouse - Fredrickson - petechiae on upper extremities, head, neck, purpura 12-24 hours. Fulminant infection. Possibly accompanied by disseminated intravascular coagulopathy (DIC).

Normal or elevated WBC.
Positive blood culture.
Possible Congestive Heart Failure.
Hypotension.
DIC - check split firrin products.
EKG - myocarditis.
CSF - elevated PMN, positive gram stain.

14) Upper respiratory or lower respiratory infection sinusitis, otitis media.

PMN with intracellular gram negative coccibaccilli.

15) Cranotomy, myelogram SBE, sinusitis osteomyelitis, direct implantation are causes of Staph, aureus infection.

Craniotomy and anesthesia can cause gram negative infection.

16) Adult usually pneumococcus or meningococcus unless surgery performed, then Staph Aureus.

Treatment - Penicillin G 20-30 million units per day in divided doses.
If allergic: chloramphenicol 100 mg per kg/day divided doses every six hours

H. Influenzae
  Ampicillin 400 mg/Kg IV q4h
  Chloramphenical 100 mg/kg

17) Aseptic meningitis - gradual onset, no conjunctivitis, all signs and symptoms are minimal, but CSF is positive.

18) Bacterial, viral, fungal, rickettsial, amebiasis, noninfections.

19) Bacterial
  Spirochetal lues
  Heptospirosis
  Listeria Monocytogenes
  Mycoplasma pneumonia
 Subdural, epidural hematomas
 Abcesses
 Cavernous sinus thrombosis

20) Viral
  Arbovirus, St. Louis encephalitis
  Eastern Equine Encephalitis
  Poliomyelitis
  Herpes Simplex
  Cytomegalic virus
  Lymphocytic choreic meningitis
  Rabies, coxsackie, ECHO

Rubella, influenza post vaccination
Small pox, mumps, measles)

21) Actinomycetes
M. Tuberculosis
Norcardia species
Actinomyces species

22) Mycosis
    Histoplasmosis
    Coccidioldomycosis
    Cryptococcus
    Blastomycosis
    Aspergillosis, candida, paracoccidioides

23) Rickettsial: Typhus, Rocky Mountain Spotted Fever
Protozoa Amebia, Naegleria
Echinococcus, trypanosomosis, toxoplasmosis
    Malaria

24) Leukemia
Lymphoma
Carcinomatosis
Collagen vascular diseases LSE, periartertitis nodosa, temporal arteritis
Periodic disease: heptomeningitis
Mollaret's meningitis

8

UPPER RESPIRATORY TRACT INFECTION

1. a. Nine causes of Pharyngitis

   1. Group A Streptococcus
   2. Gonococcus
   3. Menigiococcus
   4. Diphtheria
   5. Infectious Mononucleosis
   6. Adenovirus
   7. Para Influenza
   8. Influenza
   9. Agranulocytosis

   b. Causes of Exudative Pharyngitis

   1. Group A Streptococcus
   2. Diphtheria
   3. Infectious Mononucleosis
   4. Adenovirus
   5. Para Influenza
   6. Influenza
   7. Agranulocytosis

2. Most cases of pharyngitis are caused by viral infection

3. Large amounts of the type-specific surface antigen, in protein may be present. Such antibodies tend to persist for may years after infection. For this reason, repeated infections with strains of different M types occur during the lifetimes of most persons, but reinfection with the same M serotype is very rare unless the type specific immune response is suppressed by penicillin therapy. The production of large amounts of M protein is correlated with the ability of Streptococcus to resist phagocytosis.

4. It has been shown that the incidence of acute rheumatic fever can be partially reduced by treatment instituted as long as 9 days after the onset of pharyngitis. When the patient has been seen within the first day or two of his infection, withholding treatment for one day more has not proved to constitute a risk. One exception to this statement involves the patient with a history of rheumatic fever.

5. To prevent the sequelae, we treat.

6. Fever 102, adenopathy, petechia, malaise and prostration, pain and soreness.

7. One cannot distinguish Streptococcal from viral pharyngitis on physical examination

8. When requesting throat cultures label it: Throat culture for group A, Beta Hemolytic Streptococci because your interest is in this

organism only (99%) of time)
Culture media
1. Menigiococci - use chocolate agar and 10% CO2
2. Gonococcus - use chocolate agar and 10% CO2
3. Diphtheria - use Levinthal's agar
Most of the bacteria (other than Streptococci) that causes pharyngitis will not be cultured on the routine media, i.e. blood agar.

9. The pharynx frequently harbors Pneumococcus, E. Coli, H. Influenza and Staphylococcus, which can cause other diseases, but not pharyngitis.

10. Erythromycin

11. A. Incorrect diagnosis either the first or second time--common mistakes are:
   1. Mononucleosis
   2. Viral infections
B. Continued reinfections
C. Poor patient compliance
D. Poor drug compliance
E. L forms

12. A. Fever
B. Pain, local or referred, sphenoid, suboccipital, anterior ethnoid, temples, posterior ethnoid-mastoid, maxillary teeth

13. Orbital cellulitis, osteomyelitis, cavernous sinus thrombosis, brain abscess
Diagnosis: tenderness over area
failure to transilluminate frontal or maxillary sinus
swelling
rhinitis
drainage from middle meatus, maxillary, frontal, ethnoid
upper meatus
sphenoid, post-ethnoid,

14. 1. hemophilus
2. pneumococcus
3. streptococcus
4. staphylococcus
5. mucormycosis
6. anaerobes

15. Treatment: 1. Drainage, 2. antimicrobials

16. Nonspecific

17. 1. Chronic cough (post nasal drip)
2. Purulent nasal drainage
3. cervical adenopathy
4. Headaches

18. Treatment: 1. Shrinkage of mucous membranes
2. adeniodectomy
3. drainage of sinus
4. surgery

19. Two types 1. Serous, 2. bacterial

20. Otitis media is a disease of the young because of
    1. position of the eustachian tube
    2. normal hypertrophy of lymphoid tissue
    3. frequency of viral nasopharyngeal infections
    4. allergies

21. Children are most at risk

22. Signs, symptoms of otitis media

	Serous	Bacterial
retraction	yes	probably
bulging	no	yes
fluid level	yes	no
perforation	no	yes

23. Pneumococcus
    hemophilus influenza (less than 4 yr.)
    streptococcus
    staphylococcus
    E. coli and gram negative rods (newborn)
    mycoplasma
    tuberculosis

24. Complications
    1. mastoiditis
    2. menigitis
    3. brain abscess
    4. lateral sinus infection

25. 1. Bacterial treatment
        1. Antibiotics - greater than one month but less than 4 years - Ampicillin
        2. Greater than 4 years-- penicillin--Penicillin

    2. Myringotomy is rarely necessary

    Serous otitis media treatment
        1. Antihistamines
        2. drainage
        3. adenoidectomy

DIARRHEA

1. Diarrhea:
   Clinically - increased frequency or fluidity of bowel movement
   Physiology - Excess water in stools

2. H_2O is mostly absorbed from jejunum by active transport of Na+ which is passively followed by water (9 liters of H_2O accumulates in the intestinal lumen from diet and intestinal gland secretion:

   3-5 Liters absorbed in jejunum
   2-4 Liters absorbed in Ileum
   1-2 Liters absorbed in colon

   Net result = 0.1 to 0.2 liters of water in feces/24 hours.

3. The predominant ionic content of fecal water secretion/24 hours: Predominant Cation is K+; Predominant anion is HCO_3- plus organis anions

Cations	Anions	
calcium	chloride	
magnesium	sulfate	
ammonium	Bicarbonate	
sodium	Other organic ions	total
Potassium	Lactate	organic
	Butyrate	anions
	Propionate	
	Acetate	

4. Five mechanisms of diarrhea
   Major
   1. Interruption of normal mucosal cell transport process
   2. Deranged intestinal permeability
   3. Presence in intestinal lumen of nonabsorbable osmotically active substances.
   4. Abnormal intestinal motility (rare)
   5. Secretion of electrolytes and H_2O

5. Examples and causes of abnormal water and electrolyte transport
   1. Bacterial diarrhea
   2. Excess amount of dihydroxy bile acids in jejunum or colon arising from bacterial overgrowth or restriction of ileum.
   3. Excess fatty acids in colon
   4. Humoral or chemical factors - excess prostoglandin F2 alpha as in ganglioneuromas, pancreatic tumors; excess gastrin as in the Z-E syndrome; excess VIP as in WDH syndrome

6. Examples of Diarrhea due to Osmotic factors
    1. Overload with nonabsorbable sugars or disaccharides, e.g. sorbitol and lactulose (mechanism is lactase deficiency).
    2. Malabsorbtion syndrome - sprue and sprue-like syndrome may also have deficiencies of disaccharidases.
    3. Excess of long chain fatty acids in the colon.
    4. Malabsorbtion of proteins - e.g.: enterokinase deficiency, Hartnup disease, etc.

The diarrhea results from the excess water that is drawn to the lumen by these excess sugars, fats, and protein products.

7. The prime example of increase transit time in the intestines is carcinoid syndrome - due to the excess of serotinin release.

8. 2 causes of "Dumping Syndrome"
    1. post gastrectomy
    2. Bilroth II procedures

Excess serotonin increases transit time resulting in rapid passage of chyme. The jejunum releases Bradykinin as a result of the introduction of the highly osmotic chyme which also increases transit time.

9. Hypomotility - Diarrhea can be caused by an overgrowth of bacteria and subsequent production of secondary bile acids: deoxycolic and lithiocolic acids which inflame the intestinal mucosa and give rise to the active secretion of Na+ and water.

10. Signs and symptoms of diarrhea due to:
    a. Staphylococcal poisoning - sudden in onset - lasting 12-24 hours.
    b. Viral gastroenteritis -last 3-5 days usually without fever.
    c. Inflammatory diseases of the colon or small intestine - diarrhea with fever, and presence of blood and mucus.
    d. Functional disturbances - chronic diarrhea, without debility & systemic manifestations
    e. Malabsorbtion syndrome - chronic diarrhea with systemic manifestations and marked debility.

11. Things to look for in microscopic and gross examination of stools
    Gross: Presence or absence of blood and mucous, weight - (max. normal wt. is 250 gm/day.)

    Microscopic:
    a. WBC's - suggest inflammatory disease
    b. Parasites - suggest infestation
    c. Fat globules - suggest malabsorbtion of Pancreatic or colonic origin
    d. Undigested meat fibers - malabsorption of pancreatic or intestinal origin.

12. Significance of:
    1. Blood - organic disease
    2. Undigested meat fibers - maldigestion either of pancreatic or intestinal origin.
    3. Fat globules - same as above
    4. White blood cells - inflammatory colonic disease
    5. Parasites - intestinal infestation

13. Test of choice for:
    1. Pancreatic insufficiency - pancreozymin - secretin test
    2. Intrinsic mucosal disease of small intestine - d-Xylose test
    3. Overgrowth of bacteria in small intestine or colon -CO2 Breath Analysis test
    4. Zollinger - Ellison syndrome - Gastrin Radio Immuno Assay

14. Special Procedures
    1. If d-xylose test suggest intrinsic mucosal disease - intestinal biopsy.
    2. If CO2 BA test suggest overgrowth of Bacteria - then quantification of intestinal bacteria count may be done.
    3. In evaluation of diarrhea of unknown cause a complete radiologic examination is recommended.
        a. Upper G.I. series
        b. Lower G.I. series
        c. Barium enema preceded by proctosigmoidoscopy

INFECTIOUS ENDOCARDITIS

1) Valvular vegetations, destruction and dysfunction of valves.

2) Fever, weight loss, fatigue, anorexia, weakness, chills, sweats, joint pain, headache, petechiae, CNS symptoms, Osler's Nodes, anemia.

Fever is most common manifestation.

3) Murmur - almost always present in left-sided endocarditis, may be functional only

Fever
Cardiomegaly
Petechiae
Tachycardia
Pallor
Hepatomegaly
Congestive heart failure
Poor oral hygiene
Hepatosplenomegaly
Lymphadenopathy
Neurological findings
Clubbed fingers
Osler's nodes
Phlebitis
Embolic phenomena

4) Skin of feet or hands, conjunctiva, sclera, palate, axilla, inguinal or truncal areas.

5) Janeway lesions small erythematous or hemorrhagic lesion on palmar or plantar surface.

Roth spots round white spots on retina encircled by erythematous area.

Osler's nodes small raised papules, white center, erythematous border, tender, on fingers and toes.

6) Splinter hemorrhages, found by placing light under finger nails; found in hand trauma, laborers, mechanics.

7) Renal infarcts at arteriolar level due to acute inflammatory reaction or an immunologic proliferative reaction.

8) Infarct, abcess, abdominal rub.

9) Infarcts due to obstruction of pulmonary artery or bronchial arteries.

10) Mycotic aneurysm from occlusion of vasovenorum of major vessels resulting in destruction of arterial wall and aneurysm.

11) Focal signs due to perivascular inflammation; diffuse signs due to embolic showers.

-5

Cavity and abcess formation.
Purulent meningitis

12) Upper respiratory tract infection
Dental procedures
Surgery
Labor and Delivery
Urinary tract infection
Cardiac Catheterization
Trauma, injuries
Genito-urinary tracts
Infection or manipulation, catheterization
Drug addiction
Burns
Insect bites

13) Congenital heart disease with high pressures and turbulence have higher incidence of infectious endocarditis.

14) Streptococcus - 60%
(Viradans most common species)
Staphlococcus Aureus - 20%

15) 15% have negative blood cultures due to insufficient number of cultures for too few days. Use of oral antibiotics.

16) Gonococcus
N. Meningitis
Brucellosis
H. Influenzae
Anaerobes
Mycobacterium
Fruncellia

17) Staphlococcus aureus or albus
Streptococcus viridans, enterococcus, pseudomonas
Fungal, candida

Lesions may occur on right or left heart valves.

18) Greatly improved survival, best with staphlococcus or streptococcus organisms.

19) Organism sensitivity, cidal concentrations

20) Treatment for 4 - 6 weeks, take cultures, follow continuously.

21) Severe heart failure, valvular disease which is treated late.

DIABETES MELLITUS

1. Incidence 5-10 million in U.S. (estimate 20% U.S. population with diathesis)

2. Definition - disease secondary relative of absolute lack of insulin → changes in body metabolism → signs & symptoms

3. Deficit of insulin and relative increase in glucagon (in D.M. glucagon is not normally suppressed by glucose) → signs and symptoms, polyuria polydipsia, absence of insulin → ↑ ketosis → ketoacidosis → coma

4.

Stages	Symptoms	FBG	GTT
Prediabetes	absent	normal	normal
latent	absent	normal	abnormal steriod or stress induced
Chemical	absent	normal	abnormal
Overt	present	abnormal	abnormal

5. Diagnosis
    a. Overt signs and symptoms present Fasting Blood Sugar 150 mg.%; 2 hr. Post-prandial 160 mg.%; Serum or plasma venous blood
    Randon glucose greater 250 mg.% in diagnostic
    b. Chemical asymptomatic
    2 hr. postprandial 160 mg.% = the diagnostic if it is between 148-160 mg.%. The diagnosis may be in question, do GTT
    c. Latent history of diabetes mellitus during pregnancy, surgery, infection - asymptomatic now 2 hr. post prandial blood sugar - normal, GTT - normal, cortisone primed GTT - diagnostic
    d. pre-diabetes - retrospective diagnosis

6. Prediabetic population
    a. parents with D.M.
    b. identical twins with D.M.
    c. female has baby >10 lbs in weight or poor obstetrical history with stillbirths

7. a. borderline 2 hr. postprandial blood sugar or normal 2 hr. elaboration if you clinically suspect D.M. do GTT

    b. interpretation
        1. Prepare- adequately 300 gm carbohydrate/day for 3 days
        2. Activity standardized for active person, bed rest → ↑ abnormality
        1. Plasma vs. blood glucose

8. Inadequate carbohydrate in diet for three days, preceding the test, fives abnormal GTT

9. Fasting blood sugar 130 = 1 pt.
1 hr. blood sugar 195 = ½ pt.
2 hr. blood sugar 140 = ½ pt.
3 hr. blood sugar 130 = 1 pt.

a. 100 gm. glucose given to all patients
b. these are criteria for nonpregnant adults
c. glucose tolerance decreases with age
d. above criteria for patients less than 50 yr. , deviance should not exceed 25D
e. Patient fasts from 12 midnight to time of test, 100 gm. glucose p.o. over 5 minute periods, and measure fasting 1 hr, 2 hr., & 3 hr. blood sugar

10. Flat curve - meaningless; possibly glucose not taken or not absorbed

11. Six hr. GTT
a. hypoglycemia syndrome
b. reactive hypoglycemia of early D.M.
(3 hr. GTT adequate for diagnosis of D.M.)

12.

Stagle (adult onset)	Brittle (juvenile onset)
Overweight	Usually diagnosed in child
less labile blood glucose	thinner
little tendency to ketoacidosis	labile blood glucose
fairly good pancreatic reserve (at least for awhile)	

13. Polyuria - osmotic diuresis
Polydypsia - response to fluid loss
Polyphagia - decreased glucose availability to cells

14. Metabolic effects of insulin
adipose tissue increase glucoe uptake, increased triglyceride synthesis, decreased free fatty acid and glycerol release
Muscle increased glucose uptake, increased glucose utilization increased glucose oxidation increased glycogen synthesis, decreased glycogen breakdown, increased amino acid release
Liver - decreased glucose production, increased glycogen synthesis, decreased glycogen, inhiblition of glyconeogenesis, ketogenesis

Insulin deficit catabolism of protein, increased blood glucose and ketogenesis

15. Differential diagnosis of polydipsia, polyuria, dehydration,
a. hypercalcemia
b. diabetes insipidis, D.M. increased osmolality of urine vs.
Diabetes Insipidus = decreased urine osmolality

16. Differential diagnosing coma
   a. hypoglycemia - clammy skin, cool, sweaty
   b. hyperglycemia - dry skin, dehydration
   c. Cerbro vascular accident
   d. drugs
   e. acidosis with wide anion gap

17. Wide anion gap
   a. diabetic ketoacidosis
   b. uremic acidosis
   c. drugs vs poisons
      salicylates
      methanol
      paraldehydl
      ethylene glycol
      Chloral hydrate
      Isopropyl alcohol
   d. Lactic acidosis
   e. alcoholic ketoacidosis

18. Reverse with insulin, electrolytes, fluid

19. Causes
   a. genetic, multigenic
   b. viral - mumps, coxsackie B, rubella
   c. anti-insulin hormone growth hormone steriods
   d. cathecholamines - (pheochromo)
   e. oral contraceptive, pregnancy, estrogen therapy
   f. obesity
   g. destruction of pancreas

20. Hyperosmolal non ketotic coma
   a. severely elevated blood glucose
   b. coma
   c. seizures
   d. dehydration
   e. no ketosis
   f. prognosis worse than D.M. with ketoacidosis

21. Lactic acidosis - increased freg. in D.M. secondary to
   a. kidney disease
   b. phenformin

22. Hypoglycemia
   a. release of catecholamines secondary to fall in blood glucose
      (sweating tachycardia, irritability, palpitations)
   b. CNS symptoms
      double vision, confusion, forgetfulness, seizures, coma, death

23. Uncontrolled D.M. defective phagocytosis of organisms (esp. fungal infection) staphylococci, anareobes, possibly myocobacteria

DIABETES MELLITUS II

1. a. macrovascular disease
   microvascular disease
   metabolic disease

2. Atherosclerosis; occurs at earlier age in diabetic population

3. lower extremities

4. Extremity is cold; dependent rubor, hair loss, thickening of nails, decreased pulses, intermittent claudication, pain at rest, gangrene, loss of limb

5. Cerebro vascular accident; classically brain stem infarct R/O hypoglycemia

6. Basement membrane thickening increased vessel permeability, capillary occlusion, ischemia

7. 10-15 year diabetic retinopathy

8. a. background retinopathy, waxy exudate or macular edema, possible blindness (3%)
   b. malignant or proliferative retinopathy. 30-60% blindness; thin walled capilliary vessels rupture easily, sudden loss of vision (possibly transient) → lead to scar tissue formation which pulls on retina and causes retinal detachment with possible hemorrhagic glaucoma.

9. Nephropathy - arteriosclerosis, diffuse and nodular glomerulosclerosis, pyelonephritis, clinical picture of nephropathy, proteinuria, edema, hypertension, renal failure

10. a. Mononeuropathies - crainal neuropathy
    Sensory neuropathy
    Radiculopathy (nerve root)
    Mononeuritis multiplex

11. Cranial nerves III, IV, VI
    III may be involved in aneurysm of circle of Willis, pupillary response i spared in diabetic neuropathy, and lost in aneurysm of circle of Willis

12. Single nerves involved in various sites in body. Clinical manifestation foot drop, wrist drop; painful nerves, numbness

13. Autonomic a. hypotonic bladder
    b. diarrhea
    c. orthostatic hypotension
    d. impotency
    e. retrograde ejaculation

14. amyotrophy - muscle wasting associated with pain and deep tendon reflex loss

15. Accumulation of sorbitol in lens secondary to hyperglycemia

16. Lipodystrophy - fat in area of injection disappears, lumps up in adjacent area. Avoid with more purified insulins

17. More insulin their previously is required "classical more than 200 u. is required

18. Dietary cheating or incorrect diet, occult infection, pregnancy

21

PERICARDITIS

1. a. To protect heart from infiltrate from lungs
   b. Save lungs from mechanical trauma of heart motion
   c. Maintain heart position

2. Paradoxical pulse is a decrease in arterial pulse pressure greater than 10 mmHg on inspiration. Use blood pressure cuff and monitor change of first korokoff sound with respiration.

3. Paradoxical pulse occurs in constrictive pericarditis. Pericardial effusion, tamponade, COPD and asthma.

   Normally inspiration decreases intrathoracic pressure and increases pulmonary vasculature volume decreasing return to left ventricle, decreasing stroke volume and therefore decreasing blood pressure

   Effusion or tamponade may markedly decrease return to right ventricle, further enhancing changes with respiration.

   Neck vein distension with inspiration may occur (Kussmaul's sign)

4. a. acute fibrinous pericarditis with or without hemorrhagic
   b. effusive
   c. adhesive
   d. constrictive

5. Acute idiopathic - nonspecific
   acute myocardial infarct
   post myocardial infarct syndrome
   trauma
   post thoracotomy syndrome 2-3 months post operative
   Collagen Disease - rheumatic fever, discoid lupus, scleroderma
   Infective - bacterial - Staph, Strep. pneumococcus menigococcus
   Tuberculosis
   Fungus
   Viral
   Primary or Metastatic Malignancy, lymphoma, leukemia, bronchogenic or breast cancer
   Radiation
   Aortic aneurysm
   Drug s: hydralizine, procainamide

6. Chest pain is similar to that of acute myocardial infarct, usually no radiation, referred to trapezius or back of neck via phrenic nerve

   Differential diagnosis can be made by having patient change position breating in deeply resulting in increasing pain, sitting forward, or laying on left side having increased pain.

7. Friction rub is best heard over apical area or along left sternal border. Need good stethoscope with bell. Requires light pressure Have patient sit up and lean forward.

   A friction rub has the following characteristics, changes with time has three components, agrating or scratching quality, increases with extension of neck, is still present when patient stops breathing.

8. The components of a friction rub occur during ventricular systole, phase of rapid ventricular filling and atrial systole.

9. Pulmonary friction rub stops when breath is held.

10. Kussmaul's sign is neck vein distension occuring with inspiration. It is indicative of a decrease in right ventricular filling or increasing right ventricular pressure.

11. Ewart's sign occurs with pericardial effusion. It consists of bronchial breathing, increased whispered breath sounds, egophony and dullness to percussion, all at the inferior angle of the left scapula. (Due to compression of lung parenchyma due to pericardial effusion).

12. Acute pericardial effusion of approximately 200 ml. can result in death of syncope.

    Chronic pericardial effusions, up to 1000 ml., result in fatigue, decreased tolerance to exercise before right heart failure

13. EKG changes
    arrhythmias - supraventricular, ventricular, non-specific elevation of ST segment in leads II, III, V_5, V_6
    Q waves, T-wave inversion
    Requires differentiation from myocardial infarct

14. X-ray changes
    requires more than 250 ml. to be seen
    Cardiophrenic angle becomes more acute, increased distance between epicardial fat pad and inferior cardiac border on lateral film

    To differentiate between effusion and hypotrophy use radiopaque dye, Angiography, B scan - simplest and best

15. Same as for acute pericarditis (See 5)

16. Severe congestive heart failure, dyspnea on exertion, right heart failure, ascites, liver enlargement, neck vein distension, peripheral edema, no orthopnea, paroxysmal nocturnal dyspnea

17. Pericardial knock is due to rapid filling of ventricle during diastole later than opening snap of mitral stenosis but earlier than S3 gallop Knock is due to ventricle hitting fluid in sac as it fills

18. Cardiac tamponade is due to rapid filling of pericardial sac in Trauma, malignant disease, infection, anticoagulants, rupture of great vessels, iatrogenic injury, idiopathic, acute rheumatic fever.

19. Decreased blood flow to right heart resulting in increased venous pressure, hepatomegaly, ascites, peripheral edema, and decreased ventricular pressure resulting in quiet heart, decreasing left ventricle filling, decreased stroke volume

    Compromise is accelerated by tachycardia

20. Dyspnea, orthopnea, tachypnea, increased venous pressure, hepatic enlargement, pulsus pardoxus

JAUNDICE

I Causes of hepatitis
  A. infectious
    1. viral, yellow fever, hepatitis B virus
    2. rickettsial
    3. bacteria
  B. Toxic
    1. alcohol
    2. carbon tetrachloride
    3. trichlorethylene
    4. acetomenophen (tylenol)
  C. Allergic sulfa
  D. Sensitivity (simulates viral hepatitis)
    1. INH
    2. Alphamethyldopa
    3. Halothane
    4. methoxy fluorane
  E. Immune - chronic active hepatitis
  F. Metabolic - Wilson's disease

II Three major forms of jaundice
  A. Hemolytic Jaundice - due to pigment overload. Too much bilirubin coming to the liver. A condition which can be mistaken for this type of jaundice is congenital unconjugated hyperbilirubinemia. Isolated hepatocellular defect reducing the ability of the liver to process normal bilirubin loads

  B. Hepato Cellular Jaundice - due to liver cells which are sick.. They are unable to function properly and excrete bilirubin

  C. Cholestatic Jaundice - due to an inability of bilirubin to be excreted from the liver down to the duodenun. The defect may occur due to
    a. intrahepatic (medical) cholestasis - diseased liver cells
    b. extrahepatic (surgical) cholestasis - blockage in biliary tree by sone or tumor

III Lab Findings
  A. Hemolytic - patient has anemia, increased reticolocyte count; % of congugated Bilirubin = 20% total bilirubin rarely above 5-6 mg%

  B. Hepatocellular Jaundice: 50% conjugated of bilirubin
  Alkaline pnosphatase: normal or slightly elevated
  Cholesterol: normal Transaminase: 200-500 U Prothrobein time; correction: insignificantly by vitamin K

  C. Cholestatic Jaundice: 75% conjugated of bilirubin
  Alkaline pnosphatase: elevated Cholesterol: elevated
  Transaminase: rarely > 250U
  Prothrobein time correction: marked

IV Requirement for adequate prothrombine production by the liver is vit K and presence of normal healthy liver cell. Increase in prothrombin time after Vit. K administration is indicative of an extra hepatic defect and not "sick" liver cells

V History characterisitics - Prodrome (poor appetitie, malaise, aches and pains of muscles and joints. This suggests that liver cells are sick or intrahepatic cholestasis exists
Pain - dull, nagging, aching, RUQ pain, This is due to liver stretching 2° to retension of bile and other fluids. This is common to intra and extra hepatic lesions
Pain - narcotic required to relieve pain, severe pain located in RUQ which radiates to right scapula. This type of pain is suggestive of gall bladder stone

VI Distended Gall Bladder: excellent evidence of extra hepatic obstruction on physical examination it feels soft and squishy, like a balloon full of water; not hard. 80% of the time when distended gall bladder is palpable it means ca. of the head of the pancreas. In cholelithiasis there the patient is enough inflammation of the gall bladder that the walls are thick and scarred enough that they will not distend when the bile duct is obstructed

VII IV cholesystogram or oral cheleystogram will not be useful in patients with bilirubin greater than 2-3 mg% because one will not visualize the gall bladder
Alternatives: upper GI studies
hypotonic duodenogram
endoscopic retrograde cannulation cholangiogram
percutaneous cholangiography
tincture of time: obstruction of biliary tree has a grace period of 6-8 weeks before enough damage occurs and surgery is required

VIII Limitations of retrograde cannulation of the biliary tree
a. only able to get into biliary tree in 60% of patients
b. introduction of colonic bacteria into an obstructed biliary tree

IX Characteristics of alcoholic hepatitis

There is a prodromal period of 2-3 weeks where appetite drops, malaise, vague abdominal pain and fever, RUQ pain and enlarged liver, jaundice, WBC with leukocytosis. Unless we get a history of drinking and the prodromal symptoms we may be likely to mistake this for acute cholesistitis and operative on the patient

X Alcoholic hepatitis
Prodrome
Hx of large alcohol intake (many patients will deny this)
Liver function studies - hepatocellular pattern
cholestatis pattern
Transaminase: SGOT ↑
SGPT normal or under 100 due to vitamin 6 deficiency
Cholestrol - normal in cholestatis pattern, low in hepatocellular pattern

Cholestatic hepatitis
Liver function studies.
markedly elevated alkaline phospatase
low (rarely 250U) transaminase

XII Gilbert's disease (congenital unconjugated hyperbilirubinemia when a patient does not fell well for several days and places himself on a liquid diet. He may have icterus with a bilirubin of 2mg% conjugated normal alkaline phospatase and SGOT. No anemia and retic. count is normal . This is a congenital disease transmitted by dominant mode and is of no clinical significance. Often Dx as hemolytic jaundice due to low % of cong. bilirubin.

XI See #1 and #2

1. Effective coronary blood flow (CBF) is less than adequate to maintain myocardial O_2 consumption (MVO_2)

2. Reduces CBF

3. By coronary arteriography

4.

Class I	Intimal irregularity (minimal obstruction)
Class II	lass than 50% occlusion
Class III	greater than 50% occlusion

5. Equal distribution among right coronary artery and its branches, the left anterior descending and the left anterior circumflex arteries

6. Most of the severe lesions involve the LAD, i.e. 43% of all Class II and III lesions
   Occlusion usually occurs 4 cm from ostium in the LAD, before its runoff channels arise

7. Left anterior descending artery

8. The existence of neovascular channels, pressure gradient between diseased and patent channels

9. Neovascular channel = channels that exist at birth, that are not operational, that consist of 2 endothelial lining apposed,
   p pressure gradient between diseased and patent channels

10. Homo collateral channel - is one which originates from the same artery it enters
    Intercoronary collateral is a channel between two different coronary vessels

11. Jeopardized compensatory collateral channel arises from a vessel with disease proximal to its origin
    Non-jeopardized compensatory collateral channel arises from a healthy vessel

12. Aortic pressure head if diminished during diastole, decreases CBF
    Vasomotor reaction ↓ CBF by caliber of coronary arteries
    Viscous resistance - an ↑ in viscosity ↓ CBF
    Back pressure - elevated right atrial pressure increases the pressure in coronary veins

13. Redistribution of blood from the lower extremities increases right atrial pressure, which increases the pressure in the coronary venules and capillaries, which decreases perfusion of O_2

14. Wall stress → systolic intraventricular pressure, ventricular size and thickness
    Wall stress interval → Heart rate, ejection time
    Inotropic state of myocardium

15. When the myocardial O_2 demand is increased beyond the ability of the CBF to provide O_2

16 Severe aortic valve diseases
aortic stenosis - thickness of myocardium intraventricular pressure
aortic insufficiency - dilatation of LV, diastolic pressure (interferenc
in coronary arterial perfusion
Cardiomyopathies
    constrictive (IHSS) similar to AS
    Congestive
    floppy mitral valve
    hypoxic syndrome (syndrome X)

17. Syndrome X
Chest pain
ECG abnormalities - RST segment changes
Femal with normal blood pressure, not diabetic, normal lipids, normal mensis

18. To increase CBF - internal caliber, aortic BF, ↓ venous pressure, ↓ vasomotor reactivity, ↓ viscous resistance

19. By ↓ cholesterol concentration and other lipids it is possible to contain the evolutionary pattern of artherosclerosis
May be accomplished by: dietary restriction of cholesterol, drugs such as atromid S., cholestyramine, Thyroid extract and analogues

20. By keeping platelets from agglutinating we interfere with the basic problem of atherogenesis
May be accomplished by: heparin, coumadin, ASA and persantin

21. Saphenous vein bypass graft

22. Nitroglycerin, sublingual nitrates, diuretics, antihypertensive, propranolol, tranquilizers, sedatives, and antithyroid drugs

GENERAL CONSIDERATION OF ANEMIA

1. Lack of oxygen carrying capacity of the blood

2. Oxygen carrying capacity is the blood's ability to bind and release O_2 and dependent on the blood's hemoglobin content

3. a. hypothyroidism - tissue O_2 requirement is low
   b. high Hgb levels may be due to abnormal O_2 binding capacity of the Hgb
   c. total RBC mass may be decreased
   d. acute blood loss

Questions 4 and 5 not answered

6. Symptoms of anemia are extremely varied and range from none to severe
   Skin: pallor, especially of mucous membranes and nails. Palmar creases remain pink until Hgb is less than 8 Gm%
   Cardiorespiratory: with severe or rapidly developing anemia, symptoms of heart failure - shortness of breath, dyspnea on exertion, tachycardia, dependent edema - may develop
   Neuromuscular - headaches, tinnitus, lethargy, vertigo, "roaring in the ear"
   GI - Anorexia, flatulence, diarrhea or constipation
   GU - menstrual flow can be increased or cease; males may suffer loss of libido or potency
   Metabolic - low grade fever

7 & 8
   a. macrocytic, normochromic - MCV 103-160, MCH 32-36
   b. normochromic, normocytic - MCV 87-103, MCH 32-36
   c. microcytic, normochromic - MCV 60-87, MCH 32-36
   d. microcytic, hypochromic - MVC 60-87, MCH 20-30

9. Automated equipment is useful for rapid screening but calculates some values and averages cell sizes to get indices. In creased RBC mass gives inaccurate data

10. Bone marrow function must be evaluated

11. Reticulocyte count

12. The RPI corrects for prolonged maturation of reticulocytes in peripheral blood in anemia. It is obtained by multiplying the percent of reticulocytes by pt's Hct/45

13. Abnormal reticulocyte count indicates some degree of lack of bone marrow response (high or low) increased destruction of RBC's or blood loss. A decreased reticulocyte count indicates interference with bone marrow function, i.e., lack of building material s or replacement of bone marrow.

14. RBC are approx 1/3 size of WBC; central pallor is less than ½ of the cell diameter. Be sure to check WBC and platelets

15. Two RBC populations are present; in case shown, one hypochromic, microcytic and one normachromic normocytic

16. WBC, platelets, RBC

17. a. ovalomacrocytosis - oval RBC, hypersegmented polys.
    b. schistocytosis - broken RBC, "helmet cells"
    c. hypochromic, microcytic anemia - small, palte cells, some variation in shape
    d. Thalassemia - target cells, anisocytosis, hypochromia microcytsis
    e. hemolytic anemia - small spherocytic cells, nucleated RBC's macrocytes, Howell-Jolly bodies

18. Target cells- consider possibility of thalassemia

19. Schistocytosis and hemolytic anemia can be due to hypersplenism, disseminated vasculitis or myelofibrosis

20. Howell-Jolly bodies indicate that hemolysis is taking place there is some defective Hgb production, or the spleen is absent

21. Rouleaux formation - serum proteins are increased as in myeloma or Waldenstrom's macroglobulinemia.

22. The most common type of anemia is hypochromic, microcytic anemia Causes: iron-lack, vit B_6 deficiency, anemia of chronic disease

23. Serum iron and iron-binding capacity, Absense of stainable iron in bone marrow

24. Avidity of reticuloendothelial system for iron and supproession of RBC production

STAPHYLOCOCCAL INFECTION

1. Recognize staphylococci organism on Gram Stain
   gm(+) clusters; rather large and plump may be present as diplococci or chains

2. Recognize on blood agar
   large, mucoid; and white with surrounding rings of clear hemolysis

3. List two classes of staphylococci, idenitfy the class which most commonly produces disease
   a. staph aureus (yellow) causes of disease)
   b. staph albus (white)

4. Identify six extracellular products of staphylococcus
   a. alpha hemolysin (exotoxin)
   b. beta & delta hemolysins
   c. leukocidin
   d. enterotoxin
   e. coagulase
   f. staphlokinase

5. Explain how to separate out various types of staphylococcus aureus by phage typing. Spread staph on blood agar; add phage
   Name staph by phage lysis - certain types of staph

6. List three groups of staphylococcocus aureus;
   a. Group I - 52,52A,80,81 (phages), cause large epidemics in hospitals
   b. Group II - 3A,3B,71 cause skin disease
   c. Group III - 47,48,54,77 (less important in human disease production)

7. List factors which influence pathogenicity, detectable early in the lab
   a. color-yellow
   b. coagulase (+)
   c. ferments mannitol (+)

8. Summarize pathology and pathogenesis of staph producing disease
   a. normally skin prevents staph aureus introduction into the body
   b. debrided skin → entry of organism
   c. eleboration of exotoxin → local necrosis
   d. PMN infiltration → fought off with staph leukocidins
   e. coagulase seals off area of necrosis → later turns fibrotic
   f. Ph↓ due to necrosis; further decreases antibiotic effectiveness

9. Identify hallmark of disease; explain treatment
   a. walled off abcess is characterisitic → caseation with pus → ruptures
   b. treatment - drainage

10. Identify characteristic of staph host
    a. diabetic
    b. newborn
    c. cystic fibrotic
    d. debilitated individual with decubitus ulcers
    e. immuno-compromised host

11. List populations prone to staph
    a. diabetics - decr. local blood flow
    b. newborn (complement system not fully developed
    c. cystic fibrotic - poor drainage
    d. debilitated patient with decubitus ulcers
    e. immunocompromised host: defenses
    f. nutritionally deprived: serum defenses
    g. those on broad spectrum antibiotics - normal flow is wiped out
    h. chronic liver and kidney disease

12. Explain why staph infections are difficult to treat
    a. walled off area - antibiotic access impaired
    b. Ph prod. by organism reduces antibiotic activity
    c. staph can survive inside polymorphs
    d. fibrin membrance may keep oat cellc, antibodies

13. Identify characteristics of local infection due to staph - give most common
    a. dolori, rubor, tumor
    b. dermatologic, neonatal mastitis

14. Distinguish between furuncle and carbuncle
    a. furuncle - a single infection in follicle or sebaceous gland
    b. carbuncle - multiple areas of infection ; usually back of neck, inelasticity of skin laterilization
    large painful area with multiple ineffective drainage sites

15. Identify characteristics of staph pneumonia including population incidence, signs, symptoms, x-ray findings
    a. children 2 years of age; elderly patients
    b. occurs during flu season
    c. fever, dyspnea, tachycardia, toxemial, rales
    d. x-ray, rapidly progressive disease, pneumothorax, empyema, fistulae

16. Characteristics of staph arthritis and osteomyelitis on x-ray
    a. arthritis - large effusion around it
    b. myelitis periosteal rim around bone

17. Identify characteristics of enterocolitis including populations, signs and symptoms
    a. patients: debilitated or on antibiotics (neomycin)
    b. fever, vomiting, bloody diarrhea, intestinal sloughing
    c. abd. distension, dehydration and shock

18. Identify signs and symptoms of staph food poisoning
    a. diarrhea and vomiting with in few hours of food ingestion
    b. projectile vomiting, diarrhea without mucous

19. List two blood borne staph infections
    1. acute bacterial endocarditis
    2. sepsis

20. Characteristics of staph sepsis
    a. forms walled off abcesses usually; may circulate in blood briefly before entering tissues

21. Characteristics of staph aureus acute endocarditis virulent can destroy valves in weeks

22. Explain staph scalded skin syndrome
    a. exfoliant produced by group II staph blisters, exfoliation of skin and diseases below
       1. bullous impotigo (limited)
       2. scarlet fever

23. Characteristics of exfoliative staph disease; list diseases this can produce
    1. bullous impetigo
    2. staph scarlet fever
    3. toxic epidermal necrolysis (Lyelles disease)

24. distinguish between staph and strep scarlet fever

	Staph	Strep
strawberry tongue	(-)	(+)
palatal petechiae	(-)	(+)
pallor around mouth	(-)	(+)
tonsillar exudate	(-)	(+)
rash		
	a. large flakes	small flakes
	b. around mouth	

25. List disease states due to staph albus
    a. ventriculitis with ventriculo-cardiac shunts
    b. subacute bacterial endocarditis in drug users
    c. Urinary Tract Infection

ATTACHMENT E - 1

CULTURAL ORIENTATION COURSE

ABOUT THE FACULTY

EVELYN MAJOR is the course director for the cultural orientation component. She has been at Hahnemann since 1972, serving as director of admissions of the physician's assistant program from 1972-75. She is a clinical instructor in the department of medicine. Ms. Major received a BA degree in economics from Cornell University, and is currently a candidate for a MBA degree in health care administration from the Wharton Graduate Division of the University of Pennsylvania.

J. WARREN SALMON has been at Hahnemann since 1970. He is an assistant professor in the department of community medicine and environmental health, and has a joint appointment in the division of family medicine of the department of medicine. Mr. Salmon holds a BA degree in business administration from Drexel University and a MS degree in business and public administration from Cornell University, where he is currently a Ph.D. candidate in medical care organization and administration. He has had considerable administrative, teaching, and consulting experience in the field of health planning.

MELVIN BENARDE has been associated with Hahnemann since 1967, and is currently a professor in the department of community medicine and vironmental health. His education includes a BS in biology from St. John's University, a MS from the University of Missouri Medical School in Bacteriology and Public Health, and a PhD in microbiology and public health from Michigan State University. Dr. Benarde has written and published five books, and has had extensive teaching, research, and administrative experience in industry as well as academia.

HUGH BENNETT is professor of medicine and associate dean of HMC, a position he has held since coming to Hahnemann in 1962. He received his BS and MD degrees from the University of Chicago. His clinical and teaching career encompasses a wide range of medical experiences from three years' active duty in the USAMC during WWII to 20 years with the V.A. hospital system, and including positions at three medical schools before his arrival at Hahnemann. Dr. Bennett has served on virtually every major committee in the administrative structure of Hahnemann as well as being active in several reginnal and national committees and task forces. Dr. Bennett has an extensive bibliograply and has been the recipient of several grants during his distinguished tenure at Hahnemann

PETER SIGMANN has been at Hahnemann since 1964 when he began his medical residency. He is currently an associate professor of medicine and serves as associate chairman for primary care of the department of medicine. He is also medical director of Ambulatory Health Services for Hahnemann hospital, and medical director of the Health Service Plan of Pennsylvania, a newly organized HMO primarily based at Hahnemann. Dr. Sigmann received his M.D. degree from the University of Freiburg. In 1971 he was the recipient of Hahnemann's Lindback Award for excellence in teaching.

BARBARA MULLINS is the associate director for education of the department of nursing at Hahnemann. She has been at Hahnemann, since 1969, and holds an MPH degree from Johns Hopkins University. Prior to coming to Hahnemann, she has been a public health nurse.

BRADLEY SEVIN is a senior instructor in the division of liason psychiatry and psychosomatic medicine, of the department of mental health sciences, and has been at Hahnemann since July 1975. He completed residencies in both internal medicine and psychiatry, and received his M.D. from the Temple University.

JOHN SIMMONS is the director of Hahnemann Social Work Programs, and is a senior instructor in the department of medicine. He has an MSW degree from the University of Pennsylvania, and has been at Hahnemann since July, 1972.

ATTACHMENT E-2

SCHEDULE OF CLASS SESSIONS - CULTURAL ORIENTATION COURSE

DATE	TOPIC(S)	SPEAKERS
March 5	Introduction	Evelyn Major
	The Therapeutic Relationship	J. W. Salmon
March 12	Interview Skills	Hugh Bennett
March 19	Epidemiology	M. Benarde
March 26	Medical-Legal Issues	E. Major
April 2	Records and Record-keeping	P Sigmann
April 9	The Impact of Illness on the Patient and the Family	Maria Terehune, MSW
April 23	Health Care Facilities	Iris Cultler, MSW
April 30	Financing Health Care	E. Major
	Special Patient Problems	B. Seven
May 7	Health Manpower	E. Major and others
May 14	Health Care Problems and problems	E. Major
	Special Patient Problems	B. Seven
May 21	Special Patient Problems	M. Vergare
May 28	Written Review Exercise	

The course objectives are as follows:

1. To provide an introduction to the basic elements of health care delivery system in the United States

2. To provide some familiarity with interpersonal techniques and non cognitive aspects of health care.

3. To provide a framework for discussion of cases illustrating the above topics, in small groups and with immediate feedback from peers and staff.

4. To encourage discussion of various elements of American Health delivery and patient care in the light of previous experience in Vietnam, and try to bridge the gap medically and culturally between our two health care systems.

ATTACHMENT E - 3

CULTURAL ORIENTATION COURSE

SYNOPSIS OF RESULTS OF QUESTIONNAIRE FROM VIETNAMESE PHYSICIANS

March 5, 1976
N=47

1. WHAT INFORMATION AND SKILLS DO YOU HOPE TO ACQUIRE FROM THIS COURSE?

28 people mentioned some aspect of the American health care environment.

general - way of life, medical activity, social & economic aspects
specific - physician-hospital relationships, insurance, personal finance, establishing a practice, professional organization
Attitudinal - American medicine as a business, doctor-patient relationships, medical ethics, role of the physician, how to deal with specific religious and cultural problems.

23 people mentioned some form of social or interpersonal skills
general - relationships with patients, other physicians, physicians and other medical personnel, medical-social relationships, people in general.
specific - attitudes of American doctors and patients to FMGs, adaptation problems of FMG's in America, racial and ethnic problems and attitudes in America.

2. WHAT HAS BEEN YOUR MOST HELPFUL LEARNING EXPERIENCE SO FAR AT HAHNEMANN?

The answers to this question reflect an overwhelming concern with the immediate problems of adaptation to a new language and culture, and with passing the ECFMG.

17 people mentioned improving their English speaking and comprehension skills. Almost all the rest mentioned some aspect of the medical course.

general - review, new knowledge, lectures, preparation for the ECFMG
specific - basic science knowledge, audio-visual materials, competitive studying, handouts.
Social or personal - professors, social experiences, helpful people, experiences from American doctors, learning the American way of life, tutorship, Drs. Krishan and Clearfield, differences in doctor-patient relationships and physician's role and obligations in American society and communites.

3. WHAT HAS BEEN YOUR MOST PERSONALLY ENJOYABLE EXPERIENCE SO FAR AT HMCH?

16 people mentioned some form of interpersonal experience with Americans meeting American colleagues, getting together with

residents, teacher-student relationships, improving English through communication with Americans.

10 people mentioned interaction among Vietnamese physicians, both studying and socializing

13 people either did not answer or said "none"

Other answers were medical knowledge, improving English, discovering differences and similarities between Vietnamese and American Health care systems.

4. WHAT HAS BEEN YOUR MOST STRESSFUL SITUATION SO FAR?

20 people said finances

10 people said taking and preparing for the ECFMG

other answers included housing, family worries and separation, transportation and parking, medical and dental care.

general - getting settled and adapting to strange country, anxiety about the future

5. WHAT KIND OF MEDICAL PRACTICE SETTING DO YOU HOPE FOR IN THE FUTURE?

Two general themes emerged from the answers to this question. One is a wide disparity in the kinds of practice envisioned; the other, uncertainty between vastly different specialties or confusion concerning the requirements for specialty practice in this country. For instance, several people mentioned either or both of two different specialties, or two opposite alternative lifestyles. There appears to be a great need for knowledge among the group members concerning training for specialties and kinds of medical practice.

6. WHO ARE THREE ALLIED HEALTH PROFESSIONS WITH WHOM YOU EXPECT TO WORK AND HOW DO YOU PERCEIVE THEIR ROLES?

14 people said that they had no idea, although this question was discussed in great detail both for content and interpretation within the course

31 people mentioned nurses

16 people mentioned social workers

19 people mentioned lab or x-ray technicians

3 or fewer people each mentioned pharmacists, clerks, administrators mental health workers.

Several people mentioned other physicians either as a group or by specific specialty such as surgeon, pathologist, psychiatrist.

Only 5 people attempted any sort of role definition, and those were vague.

There appears to be a general need among group members for both overall and specific information concerning health manpower in the U.S.

COMMENTS:

ATTACHMENT E-4

THE HAHNEMANN MEDICAL COLLEGE & HOSPITAL OF PHILADELPHIA
DEPARTMENT OF MENTAL HEALTH SCIENCES
COMMUNITY MENTAL HEALTH/MENTAL RETARDATION CENTER

HOTEL PHILADELPHIA
314 NORTH BROAD STREET
PHILADELPHIA, PA. 19102 (215) LO 8 0860

July 14, 1976

TO: Dr. Krishan

FROM: Michael Vergare, M.D.

RE: Summary of 5/21/76, meeting of ECSMG

My participation in the ECSMG program consisted of co-leading a 3 hour seminar with Evelyn Major that was to focus on psychosocial issues that arise in the delivery of medical care. Our meeting followed by one week a similar meeting with Dr. Sevin and Mrs. Major, during which time role playing was used to elaborate on similar issues. One of the active members from that meeting, did not attend our meeting.

I initially meet with much resistance in re-opening the discussion. Much of the participation came initially from a middle aged physician who questioned the relevancy of any of questions raised in reference to two cases. One concerned a businessman who denied the seriousness of his cardiac condition; the other was that of a laborer whose hypertension was aggravated by self destructive behavior that included alcoholism. The group supported his view that in Vietnam patients respected doctors and were grateful for any care that might be offered. If faced with these problems they felt no need to do more than offer their treatment and if it was refused, they felt no more could be done.

My co-leader, who had met with the group regularly, noted that this was the beginning of any active expression of disagreement or anger.

The participation increased after I introduced an additional case, that of a Vietnamese soldier, who became depressed and suicidal one year after his abrupt move to this country. After initial denial that a problem such as depression existed in Vietnam, there came a gradual recollection of similar episodes at home as well as here. They spoke of colleagues who had problems making a transition to life in the United States. What was striking was the frustration they expressed with reference to american society and how difficult it was to formulate a treatment plan where an extend family or community network was lacking or obscure.

In closing, I felt I was working with a group of individuals in the midst of tremendous personal change and adjustment. Their need to focus on this specifically seemed to make it difficult for them to focus on our "agenda".

The use of a group leader such as Mrs. Major, who meet with them regularly, can foster continued discussion of these issues, although I would expect that this must continue for an extended period of time. I would view the present course as an introduction to such future discussions.

THE HAHNEMANN MEDICAL COLLEGE & HOSPITAL OF PHILADELPHIA
DEPARTMENT OF MENTAL HEALTH SCIENCES
COMMUNITY MENTAL HEALTH/MENTAL RETARDATION CENTER

DIVISION OF LIAISON PSYCHIATRY AND PSYCHOSOMATIC MEDICINE
ROOM 17311—NEW COLLEGE BUILDING
230 NORTH BROAD STREET
PHILADELPHIA, PA 19102
(215) 448-7892

July 14, 1976

MEMORANDUM

To: Krishan Bharadwaja, M.D., Director, Division of Continuing Education

From: Bradley H. Sevin, M.D., Chief, Consultation Service

Re.: Summary of the Experience of the Consultation-Liaison Service in Teaching the ECFMG - Vietnamese Cultural Orientation Course, April 30; May 7; May 14; and May 21, 1976

Contained herein is a summary of my participation in the above-mentioned program that was under the direction of Mrs. Evelyn Major. Earlier in the year, Mrs. Major and I talked at some length about her intent and plans to try to sensitize the Vietnamese physicians participating in your special program to the various difficulties that they might experience in trying to assimilate themselves into medical practice here in the United States. Among the things that I would focus my attention on primarily would be the psychological issues related to patient care; and as we began to become more involved in our discussions and experiences, it became apparent that we also would have to address ourselves to some of the psychological needs of the physicians themselves as they began to redefine their identities professionally from their previous country to the United States.

During the first two sessions, approximately an hour and a half each, my focus was upon discussing with the physicians their appreciation of the types of psychological reactions they might expect from patients as well as their reactions to the health care system as they perceived its being performed here in the United States. Very quickly the focus became not that of talking about these issues but rather a much more personalized consciousness raising experience in which the physicians talked about how difficult it was for them to become a part of the medical system here in the United States. They talked a great deal about their anxieties over taking certification examinations, specifically the worry about mastering the volume of material necessary to qualify and pass the ECFMG examination. Additionally, the physicians expressed some of their concern and frustration at mastering spoken English as well as their difficulty in relating to American physicians.

Their great concern was how they were being looked upon by American physicians and how they would be received on a professional level. Several expressed their reluctance to talk in any meaningful way about personal views because of their own cultural inhibition towards this and their own sense of insecurity as to how much they could trust the American physicians with whom they would be working. There was a general sense of apprehension and in some ways suspicion of the true sincerity and interest of the people here to offer them assistance. This indeed included not only their professional experiences but their experiences as displaced individuals coming into a foreign country and being dispersed to various areas of the country and having to adjust to that change in life pattern.

The third week was spent participating in a group discussion of "health care manpower" under the supervision and coordination of Barbara Mullin, R.N., from the Department of Nursing. This included people from the Social Work Services Department, the Consultation-Liaison Service of the Department of Mental Health Sciences, and several representatives of the Department of Nursing. By and large my impression was that there was very poor attendance during this meeting and the participation of the various Vietnamese physicians in these groups was somewhat limited and, once again, seemed to reflect a great amount of shyness and uncertainty as to just exactly what it was they hoped to learn from such experiences in terms of the health care manpower dilemmas that they might face in working with various divergent groups of professionals in medical settings here in the United States.

The fourth week was under the direction of Dr. Michael Vergare who, at my direction, presented two case vignettes (these cases and the accompanying questions and terminology are enclosed). This was done because as the physicians came closer to the end of their course work it appeared that they saw this experience as one in which they had wanted to have some specific information imparted to them and seemed quite confused about certain psychological concepts. The purpose was to present the case of an individual who manifested anxiety over medical illness in one circumstance and in another to talk about clinical depression.

My overall impression was that the time allotted to addressing ourselves to the important adjustments and reactions that these individuals were experiencing was very inadequate. The problems of assimilation and the attempts at trying to just provide a body of factual information to these physicians was something that on one level was very necessary and appropriate but did not pay much attention to the stresses and strains and personal needs that they have as a group who have been displaced and alienated from their country and past cultural background experience. There is much that still is needed in the way of opportunities available to these people in non-threatening, supportive settings so they can begin to describe and feel comfortable in relating on a personal level their concerns and fears about what it means to adjust to a new environmental setting.

During the course of my brief involvement in this experience, I have to comment on the invaluable assistance which Mrs. Major provided and the structure that she offered as a means of addressing some of these important issues. My general sense was that one of the things that this group of people seemed most concerned about was a sense of personal concern and the capacity to develop personal attachments with American physicans who could not only be understanding but also would offer genuine availability to them to appreciate the problems that they were trying to grapple with. I think that some of what we ask of these people in terms of verbalizing their concerns probably is not consistent with established cultural expectations within their own particular Vietnamese framework; and therefore made it particularly difficult for them to feel that it was appropriate to share with relative strangers anything that would be meaningful about their own personal existences at this time. At the same time I think it is important to emphasize that they clearly stated that they did have many worries and concerns and although they had a general reluctance to talk openly about this, with some encouragement and with some patience for their difficulties in expressing themselves this group, I felt, was very willing to talk candidly about important matters.

I hope that this will serve as some framework to describe part of the brief experience that I had in working together with your division in this cultural orientation program. If I do need to elaborate in any manner on any of the above-mentioned points, please do not hesitate to contact me.

Enclosures (2)

BHS:cdf

First Case

A 54-year-old bank manager with the history of maturity-onset diabetes mellitus, mild diastolic hypertension; who had been managed as an outpatient with a low salt diet and SER-AP-ES® (reserpine 0.1 mg; hydralazine hydrochloride 25 mg; hydrochlorothiazide 15 mg) one pill T.I.D. is admitted to the Coronary Care Unit with the classic findings of an acute myocardial infarction.

The patient is married and has three children (ages 20; 16; and 14). On admission to the unit he is observed to be very apprehensive and exhibits marked motor restlessness. When the staff reassures him that they will look after him and help make him comfortable, he responds by saying "There's really nothing wrong with me! You're just like my wife - always overreacting and getting upset; just call my office and tell my secretary I'll have the report due today back to her tomorrow."

During the first hospital day the patient is restless and frequently triggers the monitor warning system. He has told his wife not to bother coming to visit; he's fine; and will call her daily.

Questions:

1. What are the problems in this case?
2. What additional information would you want?
3. What are the emotional reactions of people in your culture to myocardial infarction? How do these compare with reactions you might expect here?
4. How would you manage this patient in the CCU? After he leaves the hospital?
5. During this patient's hospitalization would you inquire about this patient's sexual relationship with his wife? When would you do this? How?

Terms:

Anxiety - "apprehension, tension, or uneasiness that stems from the anticipation of danger, the source of which is largely unknown or unrecognized. Primarily of intrapsychic origin, in distinction to fear, which is the emotional response to a consciously recognized and usually external threat or danger...May be regarded as pathologic when present to such an extent as to interfere with effectiveness in living, achievement of desired goals or satisfactions, or reasonable emotional comfort."

A Psychiatric Glossary, The Meaning of Terms Frequently Used in Psychiatry, American Psychiatric Association, 4th edition, 1975, p. 16.

ICU psychosis - psychologic reaction of severely ill patients in critical care settings in which agitation; disorientation; paranoid delusions are prominent features.

Denial - a defensive psychologic mechanism, operating unconsciously, used to resolve emotional conflict and allay anxiety by disavowing thoughts, feelings, wishes, needs or external reality factors that are consciously intolerable.

References:

1. Bird, Brian: Talking with Patients, Edition 2, J.B. Lippincott Company, Philadelphia, Pa. 1973
2. Bowden, Charles L., M.D. and Burstein, Alvin G., Ph.D., Psychosocial Basis of Medical Practice, Williams & Wilkins Company, Baltimore, Md., 1974
3. Hollister, Leo E., M.D., Clinical Use of Psychotherapeutic Drugs, Charles C. Thomas, Springfield, Ill., 1974

Second Case

This is a 60-year-old black male who comes to the clinic complaining of weakness and a 15 pound weight loss over the last month. The patient is well known to the clinic, having been followed intermittently for hypertension and mild-to-moderate chronic obstructive pulmonary disease. He states that approximately a month and a half ago he stopped taking all his medications and began to drink, together with some friends, on a regular basis; and also returned to smoking cigarettes after having stopped for many years. In taking a detailed history, there is no evidence of pulmonary or cardiovascular symptomatology of any significance.

His physical examination is remarkable for evidence of mild diastolic hypertension, with blood pressure of 160/100 ml. mercury. He shows evidence of hyperinflation on examination of the chest with scattered expiratory wheezes and some limitation in respiratory excursion of the diaphragm. His heart sounds are distant. There are no evidences of congestive heart failure and only a borderline suggestion of an enlarged liver on percussion of the abdomen. The remainder of the examination is essentially unremarkable.

The patient states that he lives alone in a room in a boarding house nearby. He has been on Public Assistance for the last two years, prior to that he worked as a construction-laborer periodically for 38 years. He relates that he is separated from his wife for the last 15 years and has not seen any of his children since the separation. Recently he learned that his oldest son has become the director of a large corporation on the East Coast from reading the newspaper. He confides in you that he has been drinking very excessively during the last month. He goes on to relate that he is once again drinking as heavily as he did during the time of his marriage and indeed this was the reason for the marital separation, because of his problems with drinking.

Questions:

1. What are the problems in this case?
2. What additional information would you want in this case?
3. What are the symptoms of depression? Who are the people at greatest risk to commit suicide?
4. What would be the appropriate way to treat this patient at this time?
5. What is your understanding of the problems of alcoholism as you might expect to see them in clinical settings in the American culture?
6. Contrast the abuse of alcoholism as you understand it here with the use of drugs and alcoholic beverages in your own country.

Terms:

1. Depression - "In psychiatry a morbid state characterized by mood alterations such as sadness and loneliness; by low self-esteem associated with self-reproach; by psychomotor retardation and at times agitation; by withdrawal from interpersonal contact and at times a desire to die; and by such vegetative symptoms as insomnia and anorexia."

2. Alcoholism - "Excessive dependence on or addiction to alcohol, usually to the point that the person's physical and mental health is threatened or harmed."

References:

1. Glossary of Psychiatric Terminology from Comprehensive Textbook of Psychiatry - II, edited by Freedman, Kaplan & Sadock. The Williams & Wilkins Co., Baltimore, Maryland, 1975.

2. Manual of Psychiatric Therapeutics, Practical Psychopharmacology and Psychiatry, Richard Shader, M.D., Editor. Little, Brown & Co., Boston, 1975.

June 4, 1976

ATTACHMENT E-5

Attached is an analysis of the written review exercise which the Vietnamese physicians did on May 28 in the last cultural orientation class. Two of the four cases had been distributed prior to the first class, and were discussed as part of the first session. Half of the class discussed Rosa Lopez; the other half, Maria Luchert. The third case, Barney Timmons, was used in the lecture on the Problem Oriented Medical Record. The fourth case was new to all the physicians.

In evaluating responses, I divided the 40 doctors into 3 groups. Group one, 17 people, reported that they had attended class 10-12 times. Group 2, 16 people, reported attending 6-9 sessions. Group 3, 7 people, stated that they had attended fewer than 6 sessions. So that these groups can be compared, answers are reported as the percentage of each group which identified a given response.

I asked the physicians to record their general impressions of the course, and to state their reasons for non-attendance, anonymously if they so desired. The responses to this request are summarized at the end of the evaluation.

I look forward to an opportunity to share some observations and opinions with you and the other Hahnemann participants as part of your course evaluation. Please let me know how I can help. I hope to hear from you soon. Thank you for providing the opportunity for me to share in this very valuable learning experience.

CASE 1 ROSA LOPEZ

WHAT FACTORS PREVENTED ROSA FROM SEEKING CARE?

	1	2	3
Embarrasment, shame	65	19	14
Language	59	56	29
Transportation, distance	59	44	29
Belief in the spiritualist	59	38	29
Fear	53	25	14
Babysitting problems	47	25	29
Lack of education	47	19	29
Lack of belief in medical treatment	47	31	14
Poverty	12	44	
Lack of information about her condition		25	

WHAT FACTORS PREVENTED ROSA FROM GETTING GOOD CARE?

She doesn't believe in treatment	41	44	
Missed appointments, lack of compliance	41	31	
Ignorance	24	13	
Distance, transportation	24	25	57
Language	18	19	29
Poverty	18	19	14
Lack of information about her condition	12	13	14
Confidence in the spiritualist	12	13	14

WAS ANYONE ABLE TO HELP ROSA?

Social Worker	71	88	100
Physician	35	19	14
Visiting Nurse	18	13	
Spiritualist	12	6	
Nobody	12		
Husband	6	6	

HOW COULD THE HEALTH CARE SYSTEM OF TACKYTOWN DEAL BETTER WITH ROSA?

More or better social workers	29	25	14
Improve doctor-patient relationships	24	13	
Make Rosa feel comfortable & confident	18	13	
Admit Rosa to the hospital more easily	18	13	

COMMENTS:

1. The variety of answers to any question varied directly with the number of classes attended. That is, the people in group 1 tended to respond with many factors limiting Rosa's ability to seek and get care, listing two or three people who could help, etc. The people in group 2 did this to a lesser degree, and in group 3 still fewer reasons were given by the respondents.
2. Clustering of answers exhibited the same pattern seen above, in general. For instance, while over $\frac{1}{2}$ the people in groups 1 and 2 identified language as a barrier for Rosa, only 29% (2 out of 7) in group 3 did so. Two exceptions to this lack of clustering, or agreement, in group 3, appear. First is the identification of distance or transportation as a problem for Rosa in question 2, and the consequent lack of mention of other problems identified by the other groups. Second is the agreement that the social worker could have helped Rosa.
3. All groups recognized that people other than the physician can help with a problem having a significant medical component.
4. There were many answers given by one or two people to question 4, which are not shown. These responses indicate an awareness of the need to make the patient feel part of the system: they include such suggestions as make the patient believe in modern medicine, have a more flexible admissions policy, give better explanations to patients, have the doctors meet the spiritualist, and have better doctor-patient relationships. These answers came from people in groups 1 and 2; people in group 3 said that this is the patient's problem, that tests make people uncomfortable and cost too much.
5. In all questions, the people in group 3 tended to give more simplistic as well as briefer explanations and solutions. Those in groups one and two seemed to see more possibilities and alternatives.

CASE 2 - MARIA LUCHERT

WHAT ARE THE PROBLEMS BETWEEN MARIA'S PARENTS AND THE DOCTORS?

	1	2	3
Parents' desire for peaceful death vs. doctors' duty to treat and prolong life	53	75	14
Parents don't believe in treatment	29	31	
Money problems of family	18	6	
Not a good doctor-patient relationship	18	13	29
Father believed Maria would die			43

HOW DO YOU FEEL ABOUT WHAT DR. BLAND DID?

He did the right thing and fulfilled his role	65	50	57
He should explain the treatment to parents	12	44	29
He should call a psychiatrist	6		14
He refused to let Maria die naturally	6	6	
He should call a social worker		19	14

HOW DO YOU FEEL ABOUT WHAT THE INTERN AND THE NURSE DID?

Both did the right thing	35	56	43
The intern was right	35	31	29
The nurse was wrong to question the doctor	18	13	14

Note: Only 2 persons expressed a feeling that the nurse had cause to question the intern, and both qualified this right. One said that she was expressing the parents' feelings, the other said that she was right emotionally but wrong professionally.

CASE 3 - BARNEY TIMMONS

Myocardial infarction	65	75	57
Hypertension	59	63	71
Edema	59	25	43
Anxiety	47	25	
Chest pain, vomiting, sweating	44	25	43
Lethargy	41	19	
Hearing Loss	29	19	57
Exertional Angina	24	38	14

Note: Most doctors concentrated on making a diagnosis; only a few listed the problems. Additionally, many doctors listed conditions, vital signs, and recorded aspects of the patient's life style as problems. In general, the answers reflected a [illegible] understanding of both the [illegible] and the function of the [illegible]

CASE 4 - THE ANXIOUS DOCTOR

LIST THE TREATMENT GOALS AND PLANS FOR MRS. FRANK.

	1	2	3
Treat cardiac disease	47	56	86
Establish proper dietary regimen	35	69	57
Treat depression	29	21	
Reduce weight	29	21	57
Call psychiatrist	18	13	43
Call cardiologist	12		
Give moral support	12	19	
Obtain a social work consult		13	
Hospitalization	6	6	14

Note: The importance of Mrs. Nodd's heart disease varies inversely with the number of classes attended! While several people in groups 1 and 2 identified the need to treat more than physical problems, group 3 saw Dr. Nodd's responsibilities as limited to treatment of heart disease and obesity, and calling on the psychiatrist and social worker for such other help as is needed.

WHAT MUST DR. NODD DO TO INSURE FULL AND PROPER CARE OF THE PATIENT?

Take a complete history	29	13	
Take more time	18	19	14
Do a complete physical	12		
Try to understand the patient	12		
Educate the patient about her disease	12	25	29
Treat with diet and drugs		19	14
Call a cardiologist			29

WHAT RESOURCES ARE AVAILABLE TO DR. NODD TO CARE FOR THE TOTAL PATIENT?

Social workers	41	25	14
Nurses	24		14
More staff	18		
More doctors	12	31	43
Sufficient resources are not available	12		14
Psychiatric exam	12		
More time		25	14

LAST QUESTION - IMPRESSIONS OF COURSE

Helpful	71	70	50
Important	[illegible]	[illegible]	
Don't care because studying medicine is more important	20	60	[illegible]
[illegible] be better after passing [illegible]			

Group 1 - attending 10-12 sessions N=17

Vo Thanh Long
Trung Tan Tran
Nguyen Huu Tri
Nguyen Jam Bach
Nguyen Manh Duc
Nguyen Thi Tinh Chau
Nguyen Van Try
Hin Tong Hor
Dung Van Cai
Tuong My Suong
Ho Trung Dung
Dung Van Le
Pen Vo Lay
Khai Van Nguyen
Vu Hoat
Vu Gia An
Phan Van Duong

Group 2 - attending 6-9 sessions N=16

Vu Ngoc Oanh
Vu Tien Trong
Nguyen Kim Thuong
Nguyen Thi Tam Minh
Hien Van Le
Chi Pham M
Duc Hoang Kim
Pham, Minh Ngoc
Quan Nguyen Quoc
Hiep, Quoc Nguyen
Luu, Huy Dang
Phnoc Than Nguyen
Le Thuy Hung
Ta Si Quy
Hung Quach The
Le Qui Tu

Group 3 - attending fewer than 6 sessions N=7

Ngo Dang Tuan
Chang Dong Tran
Son Duc Dao
Bao, Nguyen Van
Cao Tic Huu
Ngoan Van Le
Tran anh Hoang

#1

THE CASE HISTORY OF ROSA LOPEZ

Rosa Lopez is a 24-year-old Puerto Rican woman living in Tackytown, Pa. with her husband and two-year-old daughter. She began to feel sick in April, suspected that she was pregnant, and went to a neighborhood spiritualist for help. He gave her a plant to eat and said that her pregnancy would be confirmed if menstruation did not occur within a week. The plant told her that she was indeed pregnant; she continued to feel very weak, was unable to eat, and was bleeding vaginally.

A visiting nurse took Rosa to see Dr. Wasp, a private physician in Tackytown, who confirmed her pregnancy, examined her, and told her to go to the clinic at Budce General Hospital where she could be treated as a charity patient. She went once, but did not keep subsequent appointments made for her at the clinic. Rosa offered varying explanations for her missed clinic appointments to the visiting nurse and the Spanish Social Worker. Sometimes she said she was too sick and just wanted to be left alone. Sometimes she complained about the distance to Budce, which was in the next town and required two transfers on public transportation; each trip involved either lengthly babysitting arrangements for her daughter or a long and tedious trip together. At other times Rosa felt frightened of the doctor, embarrassed by the exam and the questions, ashamed to discuss her symptoms, and afraid that people would make fun of her poor English. She did not take the pills she was given because she did not believe that medicine helps the body become well. She felt that if the body wants to become well, it will do so on its own.

Dr. Wasp had contacted the social worker to make followup appointments, but Rosa broke them all. He had detected cancer in situ of the cervix on his office Papanicolaou smear, and believed that Rosa should be treated promptly both medically and surgically for her condition. She was not informed of this development. Rosa refused all medical treatment except from the spiritualist until she was too weak to get out of bed. Then the spiritualist suggested that she see the doctor. Rosa

ATTACHMENT E-6

COURSE OBJECTIVES

INTRODUCTION TO HEALTH CARE IN AMERICA

1. To provide an introduction to the basic elements of the health care delivery system in the United States.
    - a. facilities
    - b. manpower
    - c. financing
    - d. medical-legal issues
    - e. records and record-keeping
    - f. epidemiology
    - g. problems and trends in American health care

2. To provide some familiarity with interpersonal techniques and non-cognitive aspects of health care.
    - a. the doctor-patient relationship
    - b. interview skills
    - c. the impact of illness on the patient and the family
    - d. special patient problems

3. To provide a framework for discussion of cases illustrating the above topics, in small groups and with immediate feedback from peers and staff.

4. To encourage discussion of various elements of American health delivery and patient care in the light of previous experiences in Vietnam, and to try to help bridge the medical and cultural gaps between the two health care systems.

ACCESS TO HEALTH CARE

Barriers between the patient and the health provider make health care less accessible than it could be. Examples of consumer-related barriers are the following:

1. SOCIOECONOMIC BARRIER. There are two sides to this problem. First, a large numer of people are poor or near-poor. Second, the cost of health care services is increasing rapidly. Lack of easy availability of health care causes poor people to behave differently around illness than those in higher socioeconomic strata. They often define illness in different terms than those commonly accepted by society, and they tend to seek care on an episodic basis and relatively late after the onset of illness. High costs, limited mobility, and lack of identity with the health care system mean that they are more likely to seek care from subprofessionals or marginal practitioners often available in their neighborhoods.

2. EDUCATIONAL AND INFORMATIONAL BARRIERS. People with high education levels usually utilize a wider breadth of health services. But even in well-educated groups, an individual family often does not know where to seek the right kind of help for a particular problem. This situation occurs because of the many different agencies, medical, and community resources which exist together.

3. PSYCHOLOGIC BARRIER. Many people either delay or fail entirely to seek medical care for psychologic reasons. These include fear of disease, anxiety about a particular diagnostic or therapeutic procedure, and apprehension of seeing the doctor.

4. CULTURAL BARRIER. Cultural and religious beliefs of patients which are different from those of providers often make health care unattainable. These include language barriers, interpretations of disease and methods of treatment. Physicians must make their services acceptable to the people involved and understandable in terms of their own culture

THE THERAPEUTIC RELATIONSHIP

I. Framework of the Therapeutic Relationship

A. Social Roles

The Physician As Healer
The Sick Role of the Patient

B. Attitudes of Practitioners and Patients

II. Activities in the Physician-Patient Process

A. Curing versus Caring

B. Assessment of the Total Patient: The Diagnostic Process

III. Factors Affecting American Medical Practice in the Present and Future

4

CONSENT TO MEDICAL PROCEDURES, OPERATIONS, AND ANESTHETICS

NAME: SEX:

WARD OR ROOM: AGE:

MEDICAL RECORD NUMBER: DOCTOR:

Patient ____________ Age ____ Marital Status ________ Time ________

Date ________________

1. I hereby authorize Dr. ____________ to perform upon me (or upon the above-named patient) the following operation and/or medical procedures: (State specific nature of operation and procedures to be performed.)

2. I consent to the performance of operations and procedures in addition to, or different from, those now contemplated, whether or not arising from presently unforeseen conditions, or possible risks attendant with the procedure, which the above-named doctor or his associates or assistants may consider necessary or advisable in the course of the operation or procedures.

3. The nature and purpose of the operation and/or procedures, possible alternative methods of diagnosis or treatment, the risks involved, the possibility of complications and the consequences of the operation or procedures have been fully explained to me. I acknowledge that no guarantee or assurance has been made as tothe results that may be obtained.

4. I consent to the administration of anesthesia to be applied by or under the direction of one of X Anesthesia Associates and to the use of such anesthetics as he may deem advisable.

5. I consent to the taking and publication of any photographs in the course of the operation or procedures for the purpose of advancing medical education. I consent to the examination, photographic studies and disposal of any tissues or parts which may be removed, by authorities of the X Hospital.

6. For the operation of sterilization, we thoroughly understand that such an operation will prevent the possibility of a future pregnancy.

7. I certify that I have read and fully understand the above consent statement which has been preceded by an explanation by my physician, that the explanations therein referred to were made to me by Dr. ____________ and are understood by me, and that all blanks or statements requiring insertion or completion were filled in before I signed.

(CROSS OUT ANY PARAGRAPHS ABOVE WHICH DO NOT APPLY)

Witness ____________ Signature ____________

Patient or Person authorized to consent for Patient stating relationship of such Person to Patient

Witness ____________ Signature ____________

Spouse of Patient(if any)

Consent Form for Volunteers

Date ______________________

Dr. ____________________, has informed me that I am about to take part in the following procedure which in whole or part is of an investigational nature:

____

____

____

He has told me how long and by what methods this procedure will be carried out. He has also explained that there is no guarantee that this procedure will be beneficial or of value in the diagnosis or management of my condition. Furthermore, he has indicated that this procedure may be associated with untoward effects some of which are not predictable. However, I understand that, in his opinion, those risks are of such a nature as to not contra-indicate carrying out this procedure in my particular case.

Having read this statement, I give my consent to the above named physician and those working under his direction and control to carry out this procedure.

I hereby waive and renounce any claims which I, my heirs, executors, or assigns might have against Dr. ________________ and the X Hospital, or any of them, as a result of adverse effects arising out of said study.

Signed: ____________________________

Witness: ____________________________

6

TWO LANDMARK MALPRACTICE CASES

CANTERBURY V. SPENCE 1972 DISTRICT OF COLUMBIA INFORMED CONSENT

Mr. Canterbury, the patient, brought suit against his surgeon, Dr. Spence, and also against the hospital where his operation had been performed. After undergoing a laminectomy, Canterbury had progressed according to schedule for 24 hours, until he fell out of bed while unattended. A few hours after the fall, severe paralysis ensued. Patient sued four years after operation, two years after attaining majority (reaching legal adult age) to collect damages for

1. negligence during the operation
2. failure of the doctor to disclose risk of paralysis inherent in the operation
3. negligent post-operative care

The issue in terms of informed consent was whether the one per cent risk of paralysis resulting from a laminectomy was great enough so that the doctor was obligated to disclose it to the patient before the operation.

The court ruled that this risk must be disclosed, and granted damages (money) to the patient (called the plaintiff) in this case. This is significant because it clearly puts the burden on the physician to prove that the patient has been adequately informed. The guideline is that the patient must be told "what the patient would want to know".

DARLING V. CHARLESTON COMMUNITY HOSPITAL 1965 ILLINOIS CORPORATE RESPONSIBILI

A young boy (Darling) hurt his leg while playing football and was brought to the hospital where Dr. Alexander, a general practitioner who was hired by the hospital to cover the emergency room, set his leg. During the following week of his hospitalization, Darling was in much pain. Nurses noticed and recorded on his chart that his toes were becoming discolored and that an unpleasant odor was emanating from his cast. Dr. Alexander saw his patient daily and prescribed pain-killers. He finally cut the cast in an attempt to relieve the pain. After ten days, Darling's parents transferred him to another hospital, where, despite the efforts of the chief orthopedist, the boy's leg was amputated 8 inches below the knee

The family settled out of court with Dr. Alexander for $40,000. The significance of this case is that the court also held the hospital responsible for the quality of care being delivered, and awarded Darling $110,000 on these grounds. Three different kinds of standards were cited to support the patient's claim that Dr. Alexander should have requested a consultation. First, licensing statutes of the state; second, JCAH standards, and third, the bylaws of the medical staff organization all require consultations on difficult cases. Dr. Alexander failed to consult with his colleagues, and therefore he and the hospital as well failed to fulfill their obligations.

7

TRAGEDY ON WOLF ISLAND

Tragedy struck Wolf Island one day last summer during a severe thunderstorm. Mrs. Knight was injured while trying to dock her small boat; she suffered a serious blow to her head and went into a coma. Since the storm prevented summoning aid from the mainland, a doctor had to be sought from among the vacationers visiting the island. Dr. Meinhard, a board-certified neurosurgeon, was summoned to give assistance, but, although licensed to practice in the state, he refused to respond to the call, pleading, by way of an excuse, the lack of facilities necessary for successful treatment. Dr. Rex, a general practitioner, was the only other doctor available, and he came immediately to lend his aid. Dr. Rex's diagnosis was that the concussion had released fluids into Mrs. Knight's cranium and that death was imminent if the pressure was not relieved immediately. Despite his lack of experience in cranial surgery, Dr. Rex determined that he would have to operate and drill two small holes into the woman's skull. With the exception of Mrs. Knight's 7-year-old daughter, no relatives were available to give consent to the operation. Mr. Knight was on the island but could not be located during the storm. Dr. Rex decided that it was best not to wait, and, obtaining the basic instruments necessary for the operation from the island's extensive emergency first-aid unit, he began the operation.

Shortly after Dr. Rex had begun, Mr. Knight was located and arrived on the scene. When he learned that Dr. Rex was only a G.P. he ordered him to stop the operation immediately. Dr. Rex refused to stop. He completed the operation and Mrs. Knight survived; but it soon became apparent that she had suffered brain damage which left her partially paralyzed.

Analyse the following grounds (reasons) for Mrs. Knight's suit against Dr. Rex:

1. Dr. Rex had no right to begin the operation without first obtaining her consent or that of her next-of-kin.
2. Even though he had begun, Dr. Rex was legally bound to stop when so ordered by her husband (next-of-kin)
3. The performance of brain surgery by a G.P. is illegal and an unauthorised practice of medicine. Such procedures can be attempted only by one with the proper board certification.
4. The resulting paralysis is evidence of RES IPSA LOQUITUR and Mrs. Knight does not have to prove Dr. Rex's negligence.

Analyse Mrs. Knight's chances of a successful suit against Dr. Meinhard for his refusal to treat her in an emergency, assuming that Maine has a Good Samaritan law.

MEDICAL-LEGAL TERMS

8

GOOD SAMARITAN LAWS provide some degree of protection from negligence suits for doctors who aid emergency victims. They generally state that the doctor is not liable for civil action in services rendered in an emergency except for gross negligence or if he expects remuneration.

STATUTE OF LIMITATIONS is the period after an event takes place when the parties to the event are legally liable. In malpractice, the statute of limitations begins when the doctor-patient relationship ends, or when malpractice should have been discovered.

DOCTOR-PATIENT PRIVILEGE means that anything which the doctor learns while treating a patient cannot be divulged in a lawsuit except with the consent of the patient.

ASSAULT: unconsented encroaching
BATTERY: unconsented touching

EMERGENCY DOCTRINE states that a doctor can presume consent to a procedure if there is a real emergency and there is no time to get consent from relatives (implied consent)

EXTENSION DOCTRINE: a doctor's legal ability to go beyond what was originally agreed to by the patient due to the doctor's exercise of "sound medical judgement".

THERAPEUTIC PRIVILEGE: patient's condition would be adversely affected by disclosure of risk involved in a medically indicated procedure.

RES IPSA LOQUITUR: the thing speaks for itself. In malpractice, a gross error, typified by the forgotten sponge.

CHARITABLE IMMUNITY: a charitable institution is not responsible for its torts

CORPORATE RESPONSIBILITY: The medical and administrative staffs of a hospital are responsibile for supervising the quality of care given within their institution

DOCTOR-PATIENT RELATIONSHIP

The tendency for people to judge each other by what they ought to do, rather than to try to understand what they are doing, is often present in the doctor-patient relationship. Rather then perceiving patients as they are, the health professional views the patient according to preconceived attitudes of how "good" patients should behave. This tendency toward moralistic judgements rather than understanding based on fact and reason will impinge severely on the doctor-patient relationship. Without eliminating values from the therapeutic relationship, the health professional must strive for insight into the influence of values, how they are acquired and used in structuring social relationships. Thus, the stereotypes of the "good" patient (who is cooperative, unquestioning, compliant, grateful) and the "bad" patient (who is belligerent, does not follow orders, questions the knowledge of the health professional, or calls the doctor frequently at inconvenient times with irrelevant or trivial questions) may be broken down and replaced with an attempt to view each patient, as an individual, to be understood and helped in the context of his/her own value system.

THE CASE HISTORY OF STELLA PAGANO

Stella Pagano is a 55 year old Italian-American female. She is 5'4" tall, weighs 180 pounds, and has a 25 year history of diabetes mellitus. She has been treated in the clinic of University Hospital for her disease for the past 23 years. On January 3, Mrs. Pagano was admitted from the emergency room in congestive heart failure. This is her fourth such admission. There is no mystery about her physical condition or the requirements for the management of her illness. She has always tolerated insulin well and is faithful about taking her medication. However, maintaining her diet properly to control her diabetes is a chronic problem to the medical and house staff.

On this admission, she revealed that she had eaten a large meal of spicy Italian food heavy in carbohydrates the night before her present attack. She admitted realizing that this food violated her prescribed diet, but explained that the family celebrated the marriage of a niece at her home which made it impossible for her to restrain herself. Dr. Schmidt, a resident in internal medicine who has followed her in the clinic during the past year, grew very impatient. He had heard similar stories from Mrs. Pagano each time she came to the clinic. As he leafed through her chart, he saw numerous notes from similarly exasperated physicians year after year denoting frustration and disgust with Mrs. Pagono's lack of motivation to control her diet.

Mrs. Pagano is extremely friendly and jovial, and always generates a feeling of warmth among the clinic staff, even as they are scolding her for neglecting her diet. She often arrived at the clinic with a fresh-baked cake or batch of cookies, and always brought with her the latest snapshots of the newest grandchild or son in-law. She obviously enjoyed a central role in her large family, which consisted of her husband, four brothers and their families, five grown children, their various spouses, and 12 young grandchildren. One unmarried son and one married daughter and her husband and two small children live with Mr. and Mrs. Pagano. This daughter works during the day while her husband attends law school. Mrs. Pagano cares for the children and prepares all the meals for this large family. She reports that there is almost always company for dinner, as all her children and her brothers live in the same neighborhood and maintain an extremely close family relationship. According to Mrs. Pagano, everyone is busy and separated during the day, and they look forward to dinner as the time to be together and enjoy each other.

At her discharge on January 10, Dr. Schmidt curtly and brusquely informed Mrs. Pagano of the dangers of neglecting either her diet or her medication. She cheerfully accepted his recommendations and agreed to cooperate, as was her usual reaction. In fact, she had never successfully carried out the doctor's orders from one visit to the next. Following this discharge, in a new experimental program, a fourth-year medical student named Michael Donatetti was assigned to her case to follow her on an outpatient basis. Mr. Donatetti saw Mrs. Pagano several times in the outpatient clinic and visited her at home on three occasions.

Six months later Dr. Schmidt saw Mrs. Pagano again at the clinic. For the first time in her long history, Mrs. Pagano had maintained her diet and was able to reduce her visits to the clinic. A feeling of confidence seemed justified that she would continue with the requirements to manage her medical problem. She was cheerful and pleased, but no more so than on previous occasions. She seemed unimpressed with Dr. Schmidt's pleasant surprise at her progress, especially her loss of 18 pounds. In fact, Dr. Schmidt noted that she seemed less eager to please him, seemed to listen less carefully to what he said. Nevertheless, two years later, Mrs. Pagano continues to be a well-controlled diabetic. She now weighs 150 pounds, attends the clinic only every three months, and has had no further hospitalization.

QUESTIONS

1. What was happening in the interaction between the patient and her physicians?
2. Why was the early treatment so ineffective and what happened to change her behavior?

FAMILY CASE

The nuclear family continues to be the most basic unit of social organization in the United States. Wide differences, though, do occur in family structure and dynamics given various class, racial, and ethnic backgrounds. Consideration must be given to these differences by health professionals.

Within the last five years, family practice residencies have begun in many hospitals across the country with physicians in this specialty to replace the general practitioner. The intent of family practice is to provide full primary care to each member within the family context. The growing literature from the mental health sciences on the family and family therapy has given emphasis to the etiologic factors for both emotional and physical aspects of disease and to the necessity for considering the family context for treatment and management of the patient's case.

The following case highlights how the complexities of the family affect the medical care process. It also demonstrates the necessity for the assessment of the total patient within the family context.

THE CASE OF SARAH REILLY

Sarah Reilly is a 35 year old married female. She has been complaining of multiple joint pains of two years duration. Her symptoms had been under fairly good control with high doses of aspirin. Recently, Sarah has had increasing swelling, pain, and limitation of motion of the left knee, and is no longer comfortable with aspirin therapy. She has been hospitalized. Her physician finds no marked changes in her pathophysiology; Sarah feels that surgery is indicated for her increasingly severe symptoms which make her unable to function in her role as homemaker and mother.

The patient is the only child of Jewish immigrants, and was raised in an extremely protective, solicitous environment. She describes her childhood as very happy, and says that she was always given whatever she wanted, although her parents were not financially secure. Sarah's parents wanted very much for her to attend college and become a teacher; they were distraught when she chose instead to marry John Reilly, her high school sweetheart. There followed a period of estrangement between Sarah and her parents, who had formerly been extremely close. The parents disapproved of John because he was not Jewish, because he did not attend college, and because his job as a policeman was not one they respected.

Sarah's father died two years ago after a long illness which depleted the financial resources of the parents. Her mother, forced by loneliness and financial dependence to reconcile with Sarah, lives with the Reillys. She suffers from colitis and has been depressed since her husband died. The mother is described as demanding, helpless, and guilt provoking.

John Reilly, age 38, suffers from frequent headaches and high blood pressure, and may be placed on disability. He is described as a devoted family man, very patient with his children, and willing to help everyone. Sarah says she has never seen her husband angry.

There are three children; Mary, age three, whom Sarah calls "the baby", cannot feed herself, is not toilet trained, and cannot talk in sentences; Margaret, age 6, was well-developed and in good health until her mother's hospitalization, when she developed stomach pains and refused to go to school; John, Jr., age nine, is in good health, doing well in school, and extremely responsible at home.

QUESTIONS

1. How would you evaluate Sarah's medical problems?
2. What would be your assessment of Sarah within the family context?
3. What treatment plans would you consider?

Department of Community Medicine
and Environmental Health

EPIDEMIOLOGY PROBLEM

Food-Borne Disease Outbreaks

I. PETERBORO OUTBREAK OF TYPHOID FEVER

On June 20, 1949, the Health Officer of Peterboro, a city of approximately 60,000 population, received case reports of five cases of typhoid fever in residents of the city. On the same day, he had received an interstate notification of a case of typhoid fever in a resident of another state, who had been a visitor in his city during approximately three of the four weeks preceding the onset of the illness. Typhoid fever had not occurred in this city during that year prior to the report of these cases. The average annual number of cases reported in this city during the preceding five years was two cases per year.

The water supply of the city is a surface supply obtained from a stream draining a relatively uninhabited section. Approximately eight years prior to the epidemic, a modern rapid sand filtration plant was installed, and the supply was chlorinated. The operation of the purification plant was under the supervision of a competent sanitary engineer. Daily reports of bacteriological analyses of water from six points in the distribution system were received by the Health Officer. The city was completely sewered, and between 95% and 98% of the houses within the city limits were connected with the city sewer system.

By city ordinance, the sale of milk, other than pasteurized or certified, was prohibited. There were two large dairies supplying approximately 75% of the milk in the city, all of which was pasteurized. There was one dairy which distributed approximately 300 quarts of pasteurized milk daily. A small but undetermined amount of unpasteurized milk was purchased in customer's containers from farmers living just outside the city limits.

Approximately 95% of the ice cream used in the city was supplied by two large manufacturers who also supplied several other cities and the surrounding area. Shellfish dealers were licensed by the City Health Department, and were required to keep records of receipt and distribution of all stock handled. Twenty-one chronic typhoid carriers were known to the City Health Department, and were under nominal supervision of the Department. A survey of the hospitals of the city and a canvas of all physicians revealed a total of 13 known or suspected cases of typhoid fever (including the case reported from a nearby state). Epidemiological data were collected by means of visits to these patients and to the homes of the patients hospitalized. A spot map of the cases showed no concentration in any area.

Table I presents a summary of the important information gained from the epidemiologic investigation of each of the 13 reported cases.

QUESTIONS

1. What possibly important fact ties together the greatest number of these cases?

2. Chart the chronology of the outbreak by date of onset of each case. From this chart, what can you guess as to a possible date of common exposure? Does this fit with the fact identified above?

3. How might you explain the apparently unrelated cases?

4. Outline briefly further indicated steps in the investigation.

Table 1. Summary of Data Relevant to Cases of Typhoid Fever in Peterboro Outbreak

Case No.	Name	Age	Sex	Occupation	Onset date	Home sanitation Sewerage	Water	Milk Supply	Ice Cream	Use of uncooked foods	Trips	Meals away from home	Bathing
1	Stella Christian	15	F	Student	6/7	City	City	Dairylea	Blair's daily	Clams 5/2	None	Daily at school; Blair's 5/2; M.E. picnic	YMCA pool often
2	Florence Blair	55	F	Housewife	6/9	Septic tank	Own well	Own cows	Dairylea	Own garden vegetables	Peterboro 5/30, 6/4	M.E. church 5/30; Potters 6/4	
3	Mary Dencher	65	F	Housewife	6/5	City	City	Borden's	Blair's rarely	Market vegetables	Lebanon 5/1-14	M.E. picnic	None
4	Flora Howard	64	F	Housewife	6/7	Septic tank	Own well	Own cows	Only home made	Oysters 5/1; fresh tomatoes	None	M.E. picnic 5/30	None
5	Theda Jones	21	F	Teacher	6/7	City	City	Borden's	Dairylea	Clams 5/21; Garden vegetables	Altaville 5/20-21	Altaville 5/20-21; M.E. dinner 5/30	None
6	Edith Ostrander	49	F	Housewife	6/11	City	City	Kingning	Dairylea 1 weekly	Garden vegetables	None	None	None
7	Walter Thurber	23	M	Mechanic	6/25	City	City	Borden's	Good Humor often	Garden vegetables	None	Shares lunch daily with fellow workers	River 6/18

Table 1. Continued

Case No.	Name	Age	Sex	Occupation	Onset date	Home sanitation		Milk Supply	Ice Cream	Use of uncooked foods	Trips	Meals away from home	Bathing
						Sewerage	Water						
8	Robert Kwiecziak	14	M	Student	6/18	City	City	Canned	None	None	None	M.E. church 5/30	River often
9	Dorothy Wagoner	16	F	Housework	6/16	City	City	Borden's	Good Humor occas.	None	None	M.E. picnic 5/30; Pep club 6/3	None
10	Grace Wagoner	44	F	Housewife	6/9	City	City	Borden's	None	None	None	M.E. church 5/30	None
11	Robert Wagoner	40	M	Grocer	6/28	City	City	Borden's	None	None	None	M.E. picnic 5/30	None
12	Alice Woods	53	F	Housewife	6/7	Septic tank	Own well	Own cows	Home made	Garden vegetables	None	M.E. picnic 5/30	None
13	Ethel Vogel	41	F	Mill worker	5/7	Pit privy	City (Charleston)	Canned	None	None	Peterboro 5/28-6/12	Sister's home-Peterboro; M.E. picnic 5/30	None

Further Investigation

An investigation at the Peterboro Methodist Episcopal Church, and inquiry directed to a number of persons known to have attended the Memorial Day celebration at the church, revealed the following information:

On the afternoon of May 30th, a Memorial Service was held at the Methodist Cemetery in Peterboro, following which a late afternoon supper was served to 33 of the persons attending the Memorial Day Service. The food served at this supper was prepared by a number of those attending, and was served as a buffet supper.

The following foods were served: potato salad, cabbage salad, macaroni salad, baked beans, spiced ham, summer sausage, buttered rolls, coffee, pickles, and 2 kinds of cake. The potato salad was supplied by 3 persons: 2 persons supplied one dish each, and one person supplied 2 dishes. One person provided one dish of macaroni salad, one person supplied a dish of baked beans, and another furnished a jar of pickles. The remaining articles, - canned milk, coffee, sugar, butter, rolls, and cold sliced meats, - were purchased at various stores in the city and delivered to the church.

Each individual attending the supper was interviewed, and as accurate as possible a record of the foods consumed by each was obtained. Previous history of typhoid fever or suggestive symptoms, as well as information concerning the preparation or serving of foods, was obtained. An attempt was made to obtain fecal specimens from all individuals attending the supper, and a series of at least 3 specimens were obtained from all persons known to have supplied food for the supper.

No histories of clearly significant antecedent illness were obtained. Laboratory studies, chiefly positive stool cultures, confirmed the clinical diagnosis of typhoid in all the 13 cases. In addition, the following laboratory data of interest were obtained on persons who attended the picnic but who remained well:

Irene Pickett - positive stools on 7/4, 7/5 and 7/6
negative stools on 7/28 and 8/2
Widal 1/40-7/14; 1/80-7/20

Margaret Bonnet - 11 consecutive positive stools, 7/2 through 10/4
Widal negative

Kenneth Rhinehardt - positive stool 7/4
3 later stools negative
Widal positive

QUESTIONS

5. Consider the status of these 3 persons- currently or previously infected?
6. What laboratory tests might be done now which were not generally done in 1939?
7. How might they help?

Table 2 is a check list, summarizing the information obtained on persons attending the picnic, the foods they ate, the sources of the foods, and who prepared and/or served them.

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Table 2. Check list of Foods Eaten at M.E. Supper

Case No.	Person	Pot. Salad	Mac. Salad	Cabbage Salad	Sausage	Spiced Ham	Baked Beans	Rolls	Cake			Coffee	Pickles
									Choc.		White		
1	Stella Christian	+	+	o	o	o	o	+		o		+	+
2	Florence Blair	?	?	o	o	o	o	+		o		+	+
3	Mary Deacher	+	o	o	o	+	ox	+x	o		+	o	o
4	Flora Howard	+	+	o	o	o	o	ox	ox		+	o	o
5	Thoda Jones	+	?	o	+	o	+	+	+		o	o	ox
6	Edith Ostrander	o	+	o	o	o	o	+		o		+	o
7	Walther Thurber*	+	o	o	o	o	o	o		o		o	o
8	Robert Kmiecziak	+	+	o	+	o	+	+		+		+	+
9	Dorothy Wagoner	+	+	+	o	+	o	+		+		+	o
10	Grace Wagoner	?	+	?	+	+	o	+		ox		+	o
11	Robert Wagoner	+	+	+	o	+	+	+	+		o	+	+
12	Alice Woods	+	+	o	+‡x	o‡x	o‡x	+x		+		+	?
13	Ethel Vogel	+	+	?	+	+	+	+	o		+	+	o
nc	George Harmon	+	o	o	o	o	+	+		o		+	o
nc	James Stoddard	+	+	+	o	+	+	+	+		o	+	+
nc	Irene Pickett X	+	+	+	o	o	+	+	+		o	+	+
nc	James Bennet	+	+	+	+	O	+	+		+		+	+
nc	Charles Carrol	+	o	+	+	o	+	+		o		+	+
nc	Gertrude Anderson*	+	o	o	o	o	o	o		o		o	o
nc	Nella Brothers	+	o	o	o	+	o	+		+		+	o
nc	Edgar Conrad	+	o	+	o	+	o	+		+		+	o
nc	Ellen Gray	+	o	o	o	o	+	+		o		+	o
nc	George Harrington	o	o	o	o	o	+	+		o		+	o
nc	Susan McAuliffe X	+	o	o	o	o	o	o		o		+	o
nc	Elizabeth Pickett	+x	o	o	+	o	o	+		ox		+	+
nc	James Sailsburgh	o	o	o	o	o	+	+		+		+	o
nc	Lillian Smith X	+	?	?x	o	o	+	+		o		+	+
nc	Margaret Bennet	+x	ox	o	o	o	o	o		+		o	o
nc	Edith Thurber X	ox	o	o	o	o	o	+		o		o	o
nc	Kenneth Rhinehardt	+	+	+	o	o	+	+		o		+	o
nc	Arlene Wagoner	+	+	+	o	+	+	+	+		o	o	o
nc	Harry Wagoner	+	+	o	+	o	+	+		+		+	o
nc	Betty Alexander**												
nc	Charles Scofield**												
nc	Magdalene Harrison	+	?	o	o	o	+	+		+		+	o

nc = not case
* = ate food (potato salad) brought home by Mrs. Thurber
x = brought or prepared food indicated
X = assisted in preparing and serving unspecified foods at church
‡ = store bought foods
** = not located

QUESTIONS

8. What are the most important points evident from this table?
9. Could you decide from this table which food was involved?

Table 3 summarizes the data in Table 2 in the form of attack rates among persons eating or not eating specified foods.

Table 3. Attack Rates Among Persons Eating or Not Eating Specified Foods*

	Persons Eating			Persons Not Eating		
Food	Total no.	No. cases typhoid	A.R.%	Total no.	No. cases typhoid	A.R.%
Potato salad	27	10(12)	37(44)	4	1	25
Macaroni salad	15	9(11)	60(73)	14	2	14
Cabbage salad	9	2(4)	22(44)	21	9	42
Sausage	9	5	55	24	8(10)	33(42)
Ham	10	6	60	23	7(9)	32(39)
Beans	17	4(6)	24(35)	16	9	56
Rolls	28	11(13)	39(46)	5	2	40
Cake (all)	18	8(9)	44(50)	15	5(6)	33(40)
Coffee	26	9(11)	35(42)	7	4	57
Pickles	11	4(5)	36(45)	21	8(9)	38(42)

* = persons who were uncertain are excluded
()= figures in parentheses include 2 silent infections

QUESTIONS

10. How should you handle instances in which a person cannot recall whether or not food was eaten?
11. Why are we concerned about rates among persons not eating particular foods?
12. To incriminate a particular food, what findings would you expect?

Attack rates were also computed with reference to various combinations of foods. Examples are given in Table 4.

Table 4. Attack Rates Among Persons Eating or Not Eating Specified Combinations of Foods

	Persons eating either or both			Persons eating neither		
Food Combination	No.	Cases	A.R.%	No.	Cases	A.R.%
Potato and macaroni salad	29	12(14)	41(48)	3	0	0
Ham and sausage	16	8	50	17	5(7)	30(41)

QUESTIONS

13. Why should this be necessary?
14. What are the possible bases for deciding which combinations to investigate?
15. What can you conclude from Table 4?

OVERALL QUESTIONS

16. Taking all available evidence into consideration, what is the complete explanation for this outbreak?
17. Are there important gaps in the evidence?
18. Are there especially important bits of information to support this explanation?
19. How can we prevent similar future episodes?

20)

II. BALTIMORE OUTBREAK IN OFFICE WORKERS

On July 19, 1951, the Bureau of Food Control, Baltimore City Health Department, learned from a friend of one of the victims that a large number of office workers (in excess of 100) had become ill after attending a picnic the previous day. The picnic was sponsored by the employees of a local insurance company.

QUESTION

20. What are the important steps that should be taken in the course of an adequate investigation of this occurrence?

The office manager of the company was requested to complete the questionnaire used by the Baltimore City Health Department in investigating outbreaks of food poisoning. The following information was obtained.

On July 18, 1951, the office personnel of the insurance company held an outing at a semi-private resort approximately 30 miles from the city in an adjoining county of the state. Traveling by private automobile and bus, 320 employees plus friends reached the resort at about 1:00 p.m. The day was cloudy, humid and warm. Upon arrival, a number participated in bathing, horseshoe pitching, golfing, and playing soft ball. Exercise was normal, not too strenuous for such an occasion. Beer and pretzels were served constantly, "as much as desired". At about 6:00 p.m. a buffet style meal was served in an open casino. The food, displayed on tables and served by temporarily employed food handlers, was sliced cooked ham, recently fried crab cakes, potato salad, sliced tomatoes, heated baked beans, sliced bread, ice cream, cake and hot coffee. Single-service containers only were used. Illness, principally nausea and vomiting, began about 2 hours after the food was eaten.

Table 1 shows the distribution of ill persons according to time of onset and symptoms of disease.

Table 1. Distribution of Ill Persons According to Time of Onset and Symptoms of Disease

Time Interval (hours)	Number of Persons		Total Number
	Emesis c̄ or s̄ diarrhea	Diarrhea only	
2	3		3
3	11	2	13
4	31	4	35
5	30	2	32
6	23	4	27
7	13		13
8	2	2	4
10	1		1
11 and over	6	12	18
Total	120	26	146

QUESTION

21. What conclusion do you draw from Table 1?

A conventional analysis of the relation of specific foods to illness is presented in Table 2.

Table 2. Attack Rates for Specified Foods According to History of Consumption

Type of foodstuff	Total eating	Incidence of illness Number	Per cent	Total not eating	Incidence of illness Number	Per cent
Ham	230	108	47	74	38	51
Crab cake	235	124	53	69	22	32
Potato salad	246	142	58	58	4	7
Tomatoes	253	127	50	51	19	37
Ice cream	201	98	49	103	48	47
Beans	258	129	50	46	17	37

QUESTION

22. What conclusion can be drawn from these data?

Table 3 presents a different method of analysis.

Table 3. Attack Rates for Specified Food Combinations

Food combination	Total eating	Number ill	Number not ill	Per cent ill
Ham	230	108	122	47
with potato salad	189	106	83	56
without " "	41	2	39	5
Crab cake	235	124	111	53
with potato salad	200	120	80	60
without " "	35	4	31	11
Potato salad	246	142	104	58
without ham	57	36	21	63
without crab cake	46	22	24	48
without ham or crab cake	103	58	45	56

QUESTIONS

23. What is the advantage of this method of analysis?
24. How do these data affect your previous conclusion?

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Around noon on December 12th, 1974, a 59-year-old white Italian woman in New York City ate a meal that included eggplant, mushrooms and peppers that she had jarred at home.

That evening she had vomiting, abdominal pain and distention of the abdomen.

On December 13th - She called her family doctor.
He furnished her with suppositories which produced diarrhea.

On December 14th and 15th (Saturday and Sunday) She complained of swallowing difficulties.

On December 16th - She had difficulty breathing.

On December 17th - Admitted to hospital.
Admitting diagnosis was Bronchitis and Respiratory Failure.

Between December 17th and 22nd - She suffered Myocardial Infarction and died on December 22nd.

(While in the hospital, she complained of burning eyes and was unable to close her eyes.)

On December 22nd - After the "wake" (funeral), the family, 22 members, returned to her home and ate the same food.

On December 24th - The daughter-in-law complained about swallowing difficulties.

On December 25th - She had difficulty talking and swallowing.
Father-in-law called the family doctor.

His impression was that her symptoms were hysterical and he prescribed a placebo.

The father-in-law called Emergency Services - got Paramedics who got her into the hospital on the afternoon of December 26th.

At the time she couldn't sit up, had a myocardial infarction and respiratory failure.

Late in the evening of the 26th, the Hospital called New York City Health Department (Epidemiologist)

The Chief of Infectious Diseases said he believed he had a case of what looked like Botulism and asked for Trivalent Antiserum - which is kept in the Poison Control Center. He then added that he believed the mother-in-law had died of Botulism too.

On the 27th, the Health Department obtained the remainder of the food that was still sitting in the kitchen - Mouse neutralization tests were performed - Type B - Clostridium botulinus toxin was found in the mushrooms.

On December 29th - Daughter-in-law died.

Inquiring among family members, it was found that in preparing the mushrooms, artichokes and peppers, they are usually cooked in vinegar to boiling - cooled, and placed in Olive Oil and stored at room temperature.

(Would anyone care to venture an hypothesis as to the mechanism of toxin production?) And how it may be prevented in future?

These vegetables are all naturally infected with Clostridial spores from the ground.

4

The Anxious Doctor

In considering anxiety, the anxiety of doctors themselves should not be entirely neglected. As has been said earlier, doctors are human and, as such, have all the feelings any of their patients can have. Also mentioned was the fact that patient material often arouses anxiety in the doctor. For some doctors this is a very painful experience, and it is one which causes some of them to stop seeing patients altogether—and who can say that that is not best?

Each doctor will of course handle his own anxiety in his own way, depending upon the defenses he most comonly calls upon. Unfortunately, there are no miraculous ways to avoid anxiety and the mistakes it may force the doctor into. It may be helpful, though, to remember that it is the patient's privilege to be more anxious than the doctor, that the patient will be more scared of the doctor than the doctor of him. For the most part, it is best that a doctor not tell a patient of his own anxiety. This might well make the doctor feel better, but it is rather an imposition on the patient. A very common tendency is to talk too much to a patient about ourselves and our families. Some doctors do this as a form of reassurance to show the patient that he is not alone in his suffering. Most of the time no help is gained from this practice, and instead it tends to stop the patient from telling more. A patient of mine told of a visit she had made to a doctor about some aches and pains and sundry other complaints. With each one recited, the doctor commented that he had had something similar, only his came on Wednesday instead of Sunday, or it was this way instead of

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that. The visit left the patient with several feelings, one being that he should have paid her and not she him; second, she was left with a humorous curiosity—what in the world would he have told about himself if she had complained of a menstrual disorder?

So it is just as well, if a patient reports that he gets indigestion from eating cucumbers, to resist the temptation to tell him we get it from eating sauerkraut. Matching symptoms with a patient may be fun and may relieve the doctor's anxiety, but it is hardly sporting, and one never knows where it will lead.

What, then, can the anxious doctor do?

That depends.

Let's say he is anxious all the time, dreads seeing patients, lies awake nights worrying about them, and because of all this anxiety does not care for his patients well. What then? In this case what the anxious doctor should do seems pretty clear. He should stop seeing patients and should switch to some branch of medicine that does not involve patient care.

But what if it is not that bad? What about the doctor who gets anxious only in particular situations?

What can he do?

Sometimes quite a bit. For one thing, he can take a reading on what kind of patients make him anxious. Are they men patients or women, the rich or the poor, the young or the old, the educated or the uneducated, the passive or the aggressive? Does his anxiousness have to do with the particular kind of illness? Is he unsure of himself with patients who have no clear-cut organic disease, no disease he can get busy treating, no illness he can cure? Is he perhaps anxious with run-of-the-mill patients, or boring ones, or hypochondriacal ones, or worried ones? Is he made anxious by working alone, and freer from worry with patients in the hospital? Is he worried about death, upset by the fragile, elderly, and severely ill—by any patient who might die on him? Is it intimate personal contact that upsets him? Does he get anxious only with long-term patients, chronic patients, patients who want to talk with him and tell him their troubles?

If the anxious doctor's self-scrutiny turns up a specific pattern or two, the next step might be to adjust his practice in order to eliminate the anxiety-producing factors. Many doctors, perhaps most, do this all the time. They adjust and refine their practice continually, almost automatically, almost as a reflex reaction to the sense of comfort and discomfort they experience with their different patients and the different ways of working with them.

The first and most basic adjustments of this kind are made while choosing a specialty. Contrary to what we tend to believe, picking a specialty and a type of practice is not based solely upon aptitude and skill but is very significantly influenced by how much at ease we anticipate being in one field as compared with others. These decisions are also made remarkably early, beginning before entering medical school and completed, as a rule, before graduation. Much of this decision-making is a matter of eliminating specialties we are sure will be unpleasant, will make us anxious, or will not yield personal satisfaction. For instance, a student who dislikes working in a "fish bowl," with people always around to look over his shoulder, may soon decide he would not like being a surgeon. Another student, recognizing that he has always been uncomfortable when alone behind a closed door with another person, is likely to decide that he will not become a psychiatrist. A student who dreads taking responsibility for life-and-death situations may find himself drawn toward a specialty which, although it may demand great skill and effort, does not deal primarily with life and death. Another student, who needs to be close to people and who likes working with them and being involved with them, soon realizes he will be anxious and unhappy in a specialty that precludes his getting to know patients.

Based on various considerations of this kind, each one of us does his best to choose a medical career which will match his usual life style and which, at the very least, will not end up in his becoming an anxious doctor. A fair number, unhappily, do not succeed and do get into work that causes various degrees of unease. Upon recognizing this, some waste no time shifting to a more congenial way of medical life. Others, however, for various reasons, make no attempt to do this and instead continue to be anxious doctors. Perhaps we do this because we feel lucky to have any patients at all and dare not shed patients who make us anxious. Perhaps we hang in there because of the hope that our anxiety is merely the anxiety of all new doctors and in time will go away. But it doesn't.

Some of us, I suspect, deliberately choose to work with patients who make us anxious. There are many people in all walks of life who do this, who try to shake off their fears by deliberately exposing themselves to whatever it is that scares them. A fair number of doctors belong to this "don't-let-it-get-you-down" school. Fearing blood, they force themselves to do things that involve cutting; fearing death, they surround themselves with the dying; or, fearing their tendency to be rough and cruel, they force themselves to do medical work demanding delicacy and gentleness. I always admire such doctors. They don't let their natural tendencies push them around. They don't give up, they push back. Sometimes they succeed. And when they do succeed, their standards of determination to push back at death and disease can be a tremendous inspiration for all of us. Often, however, they do not succeed in allaying their anxiety in this way. Although they may become exceedingly successful in their medical accomplishments, they remain just as anxious and just as uncomfortable as they ever were.

Other anxious doctors who do nothing to change to a less disturbing type of practice, do so because they are "fatalistic." They accept excessive worry as the doctor's normal condition and assume it just has to be that way. Others even feel good about their distress. The more harried they are, and the bigger the load they feel they are carrying, the tougher they can feel they are. These doctors are generally so proud of how hard their life is, they would never even consider doing anything to make things easier.

For many reasons, therefore, more than a few anxious doctors do nothing to eliminate anxiety-producing elements from their practice. Is this bad? It may be. For one thing, their anxiety may seriously interfere with their medical skill. For another, their continuing anxiety tempts them sooner or later to do the worst possible thing anxious doctors can do—take something for it. Yet how tempting it is, when worried, harried, tired, and sleepless, to turn to drugs and alcohol to make life bearable!

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How many doctors, I wonder, do just this—turn to remedies which at best are palliative and which too often end in gravest tragedy! How much better it would be if anxious doctors could feel free to turn to a psychiatrist colleague to ask him what to do about the internal problems that are the real cause of troublesome anxiety! Yet how difficult it is for anxious doctors to become patients, especially psychiatric patients!

Case 1 Special Patient Problems

A 54 year old bank manager with the history of maturity-onset diabetes mellitus, mild diastolic hypertension; who had been managed as an out-patient with a low salt diet and SER-AP-ES (reserpine 0.1 mg; hydralazine hydrochloride 25 mg; hydrochlorothiazide 15 mg) one pill T.I.D., is admitted to the Coronary Care Unit with the classic findings of an acute myocardial infarction.

The patient is married and has three children (ages 20, 16 and 14). On admission to the unit he is observed to be very apprehensive and exhibits marked motor restlessness. When the staff reassures him that they will look after him and help make him comfortable, he responds by saying, "There is really nothing wrong with me! You're just like my wife - always overreacting and getting upset; just call my office and tell my secretary I'll have the report due today back to her tomorrow".

During the first hospital day the patient is restless and frequently triggers the monitor warning system. He has told his wife not to bother coming to visit, he's fine; and will call her daily.

Questions:

1. What are the problems in this case?
2. What additional information would you want?
3. What are the emotional reactions of people in your culture to myocardial infarction? How do these compare with reactions you might expect here?
4. How would you manage this patient in the CCU? After he leaves the hospital?
5. During this patient's hospitalization would you inquire about this patient's sexual relationship with his wife? When would you do this? How?

Terms

Anxiety - "apprehension, tension, or uneasiness that stems from the anticipation of danger, the source of which is largely unknown or unrecognized. Primarily of intrapsychic origin, in distinction to fear, which is the emotional response to a consciously recognized and usually external threat or danger ... May be regarded as pathologic when present to such an extent as to interfere with effectiveness in living, achievement of desired goals or satisfactions, or reasonable emotional comfort."

ICU psychosis - psychologic reaction of severely ill patients in critical care settings in which agitation; disorientation; paranoid delusions are prominent features.

Denial - a defensive psychologic mechanism, operating unconsciously, used to resolve emotional conflict and allay anxiety by disavowing thoughts, feelings, wishes, needs or external reality factors that are consciously intolerable.

Medical Records Topic Outline

1. Purpose

-- For Patient Care - Communication
-- For Legal Reasons - Documentation
-- For Economic Reasons - Auditing/Billing
-- For Reaserch - Data Organization
-- For Teaching

2. Types

-- Emergency
-- Ambulatory
-- Hospital
-- Unit Record

3. Contents

-- Demographic Information (Face Sheets)
-- Data Base: History/Physical/Laboratory
Plan/Orders (diagnostic/therapy/education)
-- Progress Notes: Subjective/Objective/Assessment/Plan (by all professionals)
-- Laboratory Reports
-- X-ray Reports
-- Other Reports: Consultation, Special Studies
-- Flow Sheets
-- Summary (hospital record)

4. Management

-- Confidentiality
-- Preservation
-- Subpoena
-- Retrieval

Glossary

-- Problem oriented medical record: Record organized according to identified health care problems
-- Source oriented record: Record organized according to information flow
-- Demographic information: Information on patient's personal data
-- Review of systems: Review for symptoms in each physiologic system (circulatory, digestive, etc.)
-- Social History: A profile of the patient's life habits and circumstances
-- Flow Sheet: A diagram showing sequential variation of selected parameters (Blood pressure, sugar, etc.)

Patient Name [illegible] Number [illegible] Page [illegible]

Date Problems (No. and Description)	FINDINGS (Subjective and Objective)	PLANS
10-6-66	Subj Pt. is easily fatigued	
CPE ✓	anxiety about job, home	
	situations - Insomnia last	
	two weeks Drinking each	
	day for about the last	✓CBC, ✓urine, ✓X-ray, ✓cholesterol
	month Compl. that	Glucose, ✓uric acid, ✓BUN
	fingers hurt and are stiff at	
	times.	B complex 1cc
	Obj: Wt. ✓182 Ht - ✓5'7"	diet aid
	BP ✓140/85 ✓PR-68	✓flu shot Hong Kong
	Heart & lungs normal	FU with positive results
	X-ray neg	
	Vision 20/30	
	Joints not swollen, normal	
	movement of fingers	
1-5-67	Subj. Stiff finger joints. Pt.	
	says more severe after sleeping	
	or non use. General fatigue	
	stopped, occurred again in	
	last 2 weeks. Stopped drinking	✓Aspirin 10 gr. qid.
	some weight loss	✓phenylbutazone 100 mg. qid a.c. 1 wk.
#1 ✓		✓ " 100 mg bid a.c. 2 wk.
Rheumatoid	Obj. swelling & pain around	Pt. call 2 weeks
Arthritis	joints of fingers. Symmetrical	Uric acid - 4.2
	involvement.	FU visit 1 month x-ray
	X-ray narrowed joint space	
	osteoporosis at joint	
	BP - 144/85 PR-67	
	Wt - 178	

Record your findings in the unshaded column, writing through the shaded area if you wish. Record Plans in the shaded column only.

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Date 3 Problems (No. and Description)	FINDINGS (Subjective and Objective)	PLANS
2-12-67 #1 Rheumatoid arthritis	Subj. Mood improved pain reduced in morning. Obj swelling reduced pain reduced, movement normal Uric acid level O.K., No change in x-ray finding	✓Aspirin 10 gr PRN CBC CBC - normal FU - next CPE
12-3-68 CPE #2 Essential✓ Hypertension	Subj. Job-related tension. No fatigue, generally feels well. Arthritis control w/aspirin no react. Weight loss substant. but has regained. Obj: Wt. 183✓ BP - ✓170/95 PR ✓95 Heart + lungs normal Chest x-ray-neg Vision ✓20/30 joints not swollen, movement normal	✓CBC, ✓urine, ✓x-ray ✓cholesterol, ✓Glucose ✓uric acid ✓BUN, ✓PBI ✓low salt diet ✓1200 c diet ✓diazepam 5 mg tid FU - w/test results if posit. ✓low cholesterol diet FU - 2 months
2-20-69	Obj: Wt 175 BP - 150/90 PR - 80	✓Stop diazepam ✓Continue low salt, cholesterol +1200 c diet
10-5-69 #3 Myocardial✓ Infarction post Hospital	✓Hosp. for MI (8-26-69) hospital summary w/ECG included	Case - Dr. Roy Robbins - Cardiologist St. Mary's Hosp ✓Protime

PATIENT INFORMATION

Name: Gloria Stone   Date: 6/20/72   Time: 1:00 p.m.

CHIEF COMPLAINT: Nausea and lower abd. cramping with small amounts of green liq. stool 3-4 x day. Hodgkins IV B 12/69 c/o "Esophagitis and Constipation"
DURATION OF THIS PROBLEM: 2 weeks without normal B.M. and poor appetite, weak
OTHER ILLNESSES AND HOSPITALIZATION: 12/69 Hodgkins IV B RX--1/70; radiation and chemotherapy 1970-1972; exp. lap. with splenectomy 2/70
OBSERVATION OF PATIENT'S CONDITION: 23-year-old white female, R.N., with cushingoid/appearance; distended abdomen and mild epigastric tenderness, some edema legs, Ht. 5'4"; Wt. 49.5 kg; B/P rt. arm 106/70, T. 37.6, P. 120, R. 20. No petechiae on body. Gums look healthy
MENTAL/EMOTIONAL STATUS: depressed and angry. "I was doing well until this happened now what." Quieter than usual, knows she had Hodgkins.
ALLERGIES: Compazine, "makes me hyperactive."
MEDICATIONS: Prednisone 30 mg/qd with Maalox, Darvon plain for abd. pain, Dalmane 30 mg HS PRN
PROSTHESIS: None
PATTERNS:
HYGIENE: good, bathes in evening-showers if strong enough
REST/SLEEP: only 5-6 hrs./night, retires at midnight
MEALS/DIET: appetite poor with this episode
ACTIVITY STATUS: independent in activities of daily living (ADLs)
ELIMINATION/BOWEL: constipation-diarrhea 3-4 x/day--poss impaction Bladder: 4-5 x/day--occ. nocturia "mostly when can't sleep"
MENSTRUAL HISTORY-LMP: 5/25/72--normal for her
HEALTH PRACTICES: M.D. every month sometimes oftener
LIFE STYLE: prior to 12/69--worked as R.N. in ICU. Since 1970 has only worked for 1 month--late '71 to 1/72
TYPICAL DAY PROFILE: lives with parents and 15-year-old brother "who hates to visit hospitals." good relationship with parents, also has a boyfriend who "has never given up even though he knows I have a fatal disease."

PROBLEM LIST

#	Date	Problem Description

37

PATIENT INFORMATION

ame: Barney Timmons Date: 8/14/72 Time: 4:45 p.m.

EASON FOR HOSPITALIZATION OR CHIEF COMPLAINT: Left
nterior chest pain (onset while walking); vomiting;
rofuse sweating
URATION OF PROBLEM: Since 1:00 p.m. this day
THER ILLNESSES AND/OR PREVIOUS EXPERIENCE WITH HOSPITALIZATION: Myocardial infarction in 1968; exertional
ngina since then; hypertension diagnosed in 1969. In
ospital for previous MI, 1968.
BSERVATION OF PATIENT'S CONDITION: 66-year-old white
ale, is lethargic. Experiencing moderate degree of
ain. Slightly obese for body build--185 lbs., 5'6"
/P 130/90; pulse 65. Resp. 24. Pedal edema noted
ENTAL/EMOTIONAL STATUS: Cooperative to commands
riented to time, place, person; somewhat anxious.
earing deficit. ix in 1970; doesn't wear aid
LLERGIES: None
EDICATIONS: Nitroglycerine as needed; Aldomet Q.I.D.
ROSTHESIS: None
ATTERNS:
YGIENE: Has upper and lower dentures; showers each
orning
EST/SLEEP: Retires at midnight. Averages 7 hours sleep
EALS/DIET: No food intolerances; eats 3 meals per day
ax in following salt-free diet
CTIVITY STATUS: Restricted because of angina on exertion
LIMINATION: bowel--daily movement in morning after
reakfast. bladder--voids 5 times daily. No nocturia
ENSTRUAL HISTORY:
EALTH PRACTICES: Sees private physician every 4 months
IFE STYLE: married for 30 years. Two married children.
ttends Methodist church regularly--is an Elder
YPICAL DAY PROFILE: Retired city fireman. Works in
ard and garden in summer months. Enjoys grandchildren.
ports fan.

PROBLEM LIST

#	Date	Problem Description

38

NAME Theresa Marinaccio

INITIAL WORKUP

2/12/73

History of Present Illness: 8-year-old female with recurrent fever and lethargy and new symptom of knee pain 2 days ago. Antecedent 3-day episode of sore throat with difficulty swallowing, temp. of 102 and headache 3 weeks ago.

Family History: no sig. illnesses; sister had recent sore throat

Personal History: 3rd grade; good student; favorite subject math; socially well-adjusted

Past History: no sig. illnesses; no operations; no allergies including meds.

Physical Findings: ht. 52"; wt. 59 lbs.; pulse rate--124; temp. 102; BP--98/60; soft heart murmur--systolic, at apex; no objective signs of arthritis, erythema marginatum, subcutaneous nodules, choreiform movements

Laboratory Findings: urinalysis--neg.

PLANS

Date, No. Description	
# 1 2/12/73 Incomplete Data Base	Diagnostic: schedule regular new patient workup following recovery from acute illness Therapeutic: none Patient Education: none at present
# 2 2/12/73 Fever, lethargy, arthralgia, heart murmur	Diagnostic: ESR, ASO titer, ECG, chest X-ray, throat culture Therapeutic: complete bed rest overnight, plenty of fluids, pt. to return in a.m. for test results Patient Education: complete bed rest, plenty of fluids, no aspirin, if temp. reaches 103, notify physician

PROGRESS NOTES

NAME Theresa Marinaccio

Date, No. Description	Findings and Plans
# 2 2/13/73	Subjective Findings: joint pain has moved from knees to hip and shoulder; still lethargic
Rheumatic fever	Objective Findings: ESR--45; ASO titer--1,500; ECG--prolonged P-R interval; chest X-ray shows mild cardiac enlargement; throat culture--positive for B-hemolytic strep; present temperature--102; pulse rate--124; BP--98/60; murmur louder at apex; heart tones losing crispness
	Assessment: pt. has acute rheumatic heart disease based on one major manifestation (carditis manifested by cardiac enlargement and changing heart murmur) and four minor manifestations (fever, arthralgia, prolonged P-R interval, and elevated acute phase reactants)
	Plans:
	Diagnostic--follow for signs of cardiac failure
	Therapeutic--hospitalize immediately; strict bed rest; feeding by staff; begin aspirin--postprandial, 60 mg./lb. not to exceed 10 gm. daily; benzathine penicillin--single IM dose, 600,000 units
	Patient Education--rheumatic fever explained to patient and mother; encouraged about prognosis

PATIENT INFORMATION

Name: Barney Timmons Date: 8/14/72 Time: 4:45 p.m.

REASON FOR HOSPITALIZATION OR CHIEF COMPLAINT: Left anterior chest pain (onset while walking); vomiting; profuse sweating
DURATION OF PROBLEM: Since 1:00 p.m. this day
OTHER ILLNESSES AND/OR PREVIOUS EXPERIENCE WITH HOSPITALIZATION: Myocardial infarction in 1968; exertional angina since then; hypertension diagnosed in 1969. In hospital for previous MI, 1968.
OBSERVATION OF PATIENT'S CONDITION: 66-year-old white male, is lethargic. Experiencing moderate degree of pain. Slightly obese for body build--185 lbs., 5'6"
B/P 130/90; pulse 65. Resp. 24. Pedal edema noted
MENTAL/EMOTIONAL STATUS: Cooperative to commands
Oriented to time, place, person; somewhat anxious.
Hearing deficit, dx in 1970; doesn't wear aid
ALLERGIES: None
MEDICATIONS: Nitroglycerine as needed; Aldomet Q.I.D.
PROSTHESIS: None
PATTERNS:
HYGIENE: Has upper and lower dentures: showers each morning
REST/SLEEP: Retires at midnight. Averages 7 hours sleep
MEALS/DIET: No food intolerances; eats 3 meals per day
Lax in following salt-free diet
ACTIVITY STATUS: Restricted because of angina on exertion
ELIMINATION: bowel--daily movement in morning after breakfast. bladder--voids 5 times daily. No nocturia
MENSTRUAL HISTORY:
HEALTH PRACTICES: Sees private physician every 4 months
LIFE STYLE: married for 30 years. Two married children.
Attends Methodist church regularly--is an Elder
TYPICAL DAY PROFILE: Retired city fireman. Works in yard and garden in summer months. Enjoys grandchildren. Sports fan.

PROBLEM LIST

#	Date	Problem Description

PATIENT INFORMATION

Name: Gloria Stone   Date: 6/20/72   Time: 1:00 p.m.

CHIEF COMPLAINT: Nausea and lower abd. cramping with small amounts of green liq. stool 3-4 x day. Hodgkins IV B 12/69 c/o "Esophagitis and Constipation"
DURATION OF THIS PROBLEM: 2 weeks without normal B.M. and poor appetite, weak
OTHER ILLNESSES AND HOSPITALIZATION: 12/69 Hodgkins IV B RX--1/70; radiation and chemotherapy 1970-1972; exp. lap. with splenectomy 2/70
OBSERVATION OF PATIENT'S CONDITION: 23-year-old white female, R.N., with cushingoid/appearance; distended abdomen and mild epigastric tenderness, some edema legs, Ht. 5'4"; Wt. 49.5 kg; B/P rt. arm 106/70, T. 37.6, P. 120, R. 20. No petechiae on body. Gums look healthy
MENTAL/EMOTIONAL STATUS: depressed and angry. "I was doing well until this happened now what." Quieter than usual, knows she had Hodgkins.
ALLERGIES: Compazine, "makes me hyperactive."
MEDICATIONS: Prednisone 30 mg/qd with Maalox, Darvon plain for abd. pain, Dalmane 30 mg HS PRN
PROSTHESIS: None
PATTERNS:
HYGIENE: good, bathes in evening-showers if strong enough
REST/SLEEP: only 5-6 hrs./night, retires at midnight
MEALS/DIET: appetite poor with this episode
ACTIVITY STATUS: independent in activities of daily living (ADLs)
ELIMINATION/BOWEL: constipation-diarrhea 3-4 x/day--poss impaction Bladder: 4-5 x/day--occ. nocturia "mostly when can't sleep"
MENSTRUAL HISTORY-LMP: 5/25/72--normal for her
HEALTH PRACTICES: M.D. every month sometimes oftener
LIFE STYLE: prior to 12/69--worked as R.N. in ICU. Since 1970 has only worked for 1 month--late '71 to 1/72
TYPICAL DAY PROFILE: lives with parents and 15-year-old brother "who hates to visit hospitals." good relationship with parents, also has a boyfriend who "has never given up even though he knows I have a fatal disease."

PROBLEM LIST

#	Date	Problem Description

Edward Viner is an internist and hematologist. In May, 1972, he was hospitalized for excision of a tumor of his liver. What should have been a few weeks' recuperation turned into an ordeal of several months.

"To tell the truth, I hadn't felt sick at all when I went to an internist friend for a routine physical. I'm ashamed to tell you that I really had never had one and my wife insisted on it because of one of those inexplicable fears that nag pregnant women.

Anyhow, I was lying on the examination table when I noticed a brief but unmistakable look of alarm cross my doctor's face as he kept pressing on my right upper quadrant. I asked him what the problem was, and he told me my liver felt enlarged. We agreed that I'd come back next day for a radioisotopic liver scan.

"I really didn't give it much thought the rest of the day. After all, it probably was going to be nothing. But the next day was a different story. I went through the test and then sat there waiting for the radiologist to tell me everything was all right. But he just kept looking at the X-ray and saying nothing for what seemed like an eternity. I just couldn't stand that awful silence, so, I'm embarrassed to say, I literally grabbed the X-ray from him.

"When I looked at it, I went almost numb with shock. There was a huge cold area in my liver scan that looked like a hepatoma or a large metastatic lesion.

highly unlikely prospect, but I clung to it for the moment. In reality, though, I was in kind of a daze.

'The next thing I did was to call my wife, Judy, and tell her. There was no way to keep it from her even if I'd wanted to, because I would have to be hospitalized for more studies. Judy's a retired nurse, so she knew the implications of the study. Her voice quivered, but she said all those things we both desperately wanted to believe.

'After I hung up, I sat there in the X-ray department for a long time just staring at the floor. I thought about a lot of things, but mostly about our 3 children and the baby we were expecting in August. I was sure I'd never live to see the baby. And I just couldn't get through my head what was happening to me. This was something that only happened to other people, to my patients, *not* to me. I began to identify with the other patients sitting there in the X-ray waiting area, all waiting to find out if they had cancer.

'Well, later that morning I went on to have an IVP, chest X-ray, and upper GI. I was then admitted and the next morning had a bone marrow aspiration, Barium enema, and proctoscopic. These were all studies that I'd ordered lots of times on others. But I'd never realized how exhausting they are or how draining it is to sit around waiting for results. Everything proved negative — that is, there wasn't any evidence of a primary malignancy that might've spread to the liver.

'Then I had a hepatic arteriogram, which they said would be "uncomfortable," that I'd feel "warm." I'd told patients the same thing lots of times, so I was completely unprepared for the tremendously painful heat that felt like a can of vaseline exploding in my abdomen.

'Finally my doctors came back into the X-ray room with the results. My internist looked worried, but the radiologist was smiling. He told me it was a BTS study — "better than sex." He was pretty sure it was a hemangioma rather than a hepatoma.

'I felt a gush of relief — *and* I started wondering why my internist had looked so gloomy. Then I realized that it might still turn out to be a malignant hepatoma. And that even if it was a hemangioma, that would mean a horrendous operation.

'Well, then I got phlebitis, which delayed my surgery for 2 weeks. In my op, with the surgery lasting 6½ hours. The surgeon brought me the good news — it was a hemangioma, massive but at least benign. I'd had a right hepatectomy.

'At first I did well postoperatively. But then I began to have recurrent chills and fever and had to be on and off an ice blanket for the next 2 weeks. You can't imagine what a scourge that was — like lying naked in the snow. It was definitely one of the worst things I went through, which was a surprise since I'd never given that procedure a second thought when I'd ordered it for patients.

'After a month in the hospital, I'd still failed to defervesce. I was losing ground, and it was clear I'd need surgery again to drain what was probably an abscess. I knew when I went into the OR that if I woke up in my room, things had gone pretty well, but if I was in intensive care, they'd run up against problems.

'Well, the first thing I saw when I woke up was a bank of lights on the ceiling, so I knew right away that I was in intensive care. Then I noticed my surgeon and the professor of experimental surgery in the room. And then I saw the clock — 3:00 and it was dark outside, so it had to be 3 a.m. It hit me that things really must've gone wrong, because the chief of surgery isn't there at 3 a.m. for routine postop care.

'I was shivering terribly and then realized I was literally packed in ice cubes. Then I noticed that the doctors were doing cardiac outputs. My awakening was like putting pieces of a puzzle together. I came to realize that I'd developed septic shock and heart failure from volume overload. Then I heard what sounded like a motorboat next to me and realized I was on a respirator connected to an oral endotracheal tube.

'I was on a lot of drugs after that, and intermittently semicomatose, so the next several weeks are sort of fuzzy to me. I'm not sure of the exact sequence of events. But the first thing that stands out in my mind was 2 nights after the operation. I was lying there on my back with the respirator humming away, when I suddenly felt a wave of nausea. I immediately knew I'd developed gastric distention and that I was vomiting and aspirating a lot of gastric fluid. Since I couldn't talk with the endotracheal tube, I frantically signaled the nurse and tried to communicate that I was aspirating.

'She tried to reassure me that I wasn't. hadn't seen fit to wake the anesthesiologist, because it seemed to me that she was over her head in trying to manage the situation.

'I still feel that had I been successful in my desperate attempts to pull the bite block and the tube out so I could vomit over the side of the bed, I would've been able to prevent much of the damage. Apparently what'd happened was that the endotracheal tube balloon had lost its air, allowing me to aspirate around the tube when I vomited. Well, I just lay there waiting for my aspiration pneumonia to develop — which is exactly what happened.

'I knew I'd need a tracheostomy, but my doctor wanted to wait it out, to avoid it if possible. But I became so exhausted that I just couldn't continue the work of breathing. I felt like I was climbing to the top of Mt. Everest — but without any oxygen. After another day, they did the trach. This and a lot of expert manipulation of the respirator finally made me comfortable for the first time in a week.

'That's when I told my doctors that nothing in the world was more important for me for the next several hours than sleep. I told them it had to take precedence over temperature-taking, CVP measurements, aspiration — literally everything. They allowed me 2 uninterrupted hours, which helped tremendously.

'The next crisis came when I suddenly developed a massive tension pneumothorax. I can remember desperately trying to convince the nurse — via scribbled notes — that this shortness of breath was different than the other I'd had all along. Finally the respiratory therapist came by and immediately recognized what'd happened. There was a great flurry of activity and finally the chest tube was inserted. It was the first of 9 required for a series of pneumothoraces caused by the large amounts of PEEP required to keep me oxygenated.

'Because of these repeated crises and my lack of sleep, I also developed an obvious case of intensive care psychosis. It came and went. There were times when I hallucinated, was disoriented and confused. For instance, I got frantic about having blood spots on the sheet because I was convinced werewolves would come and eat them, leaving holes in the sheets that would make me cold. The nurses could see the blood spots all right, but it took them a while to figure

4/45

out why I was so upset by them.

'Sometimes I would bang on the side of my bed for attention and write a message to the nurse that the place was being robbed by the mafia. I guess a psychiatrist would interpret that as my health being stolen from me. Other times I'd think I was on a truck being paraded around the country as some kind of demonstration model. That no doubt reflected my reaction to the lack of privacy in the ICU.

'The delusions were embarrassing enough, but what was worse was being kidded along by the nurses. Even when I was confused, I could tell when they were making jokes. That just made my embarrassment worse when I came back to reality. I really think the best way to handle a patient in that state is to bring him back to reality as gently, but as firmly, as you can. My wife kept telling me calmly where I was. That was much better than the nurses' indulging my mental aberrations, no matter how well-intentioned it was.

'The most important thing I found in intensive care was that the nurses were the most important people to me — more important in that narrowly circumscribed world than the doctors even, because they were with me all day. Some were absolute angels, but others were just plain bitches. I don't know exactly what made the difference. I just know that the most important thing to a patient is that the nurse cares. Probably the least important thing to a patient is how technically capable she is. Most patients can't determine technical competence anyhow. I found myself quite willing to tolerate inexpert attempts at procedures as long as the nurse cared. It struck me as amazing how well a patient can judge a nurse's attitude, her empathy and warmth.

"The single most
frustrating
thing to a patient

'After a few weeks in the ICU, I could even tell whether a nurse had had a fight with her husband that morning or had premenstrual tension. Since the nurses were such a vital part of my existence, I found myself worrying at the end of each shift about who would be on the next one. Some of the nurses were much too rigid. For instance, I can remember one who repeatedly kept me shivering on the ice blanket for several extra hours because my temperature was 101.1 — not 101, as the doctor had ordered. And some of the nurses could make you feel like you were the one responsible for them having to work so hard. But I think the single most frustrating thing that can happen to a patient is when a nurse doesn't listen to or believe him.

'For example, one nurse was annoyed with me when I asked for a Levin tube because my stomach was distended — the very thing, of course, that had led to my pneumonia. Nothing's ever made me feel more furious or helpless than her reply — "My, my, don't we know a lot about ourselves." I finally was seen by the resident, who put in the Levin tube and removed about 1100 cc's of fluid.

'Then there was the time I kept trying to convince a nurse that I was having an insulin reaction. I was on insulin because of hyperalimentation. My dose had been constant for days, so when she brought an extra needle, I questioned it. She said, "Don't try to be your own doctor." And she gave it to me.

'I realize that wasn't entirely unreasonable, but she could at least have given my objection *some* thought. About 2 hours later I had all the classical symptoms of insulin reaction. And then, not only couldn't I get the nurses to listen to me — I couldn't get any of the *doctors* to listen. (By the way, this whole issue of not listening to patients applies as much to doctors as it does to nurses.) Fortunately a doctor friend of mine stopped by, saw me in a cold sweat, agreed with me and got me some glucose. through the long, frightening process of being weaned from the respirator, so I could leave the ICU and go to a regular floor. What a distressing time that was! I was afraid of leaving my friend, the respirator — and I truly thought of it as a friend — yet I also was afraid that I might be a pulmonary cripple for the rest of my life. By the last week in the ICU, I didn't have any emotional strength to draw on. I just couldn't stop the lip-quivering and crying. I'd seen patients in the ICU lose emotional control before, but I'd never really understood why until I'd been through it myself.

'After leaving the ICU, I spent 4 weeks doing breathing and other exercises, working hard in the rehab department, and so on. I finally was able to leave the hospital in September — about 120 days after I'd gone in for my "routine physical" and just a few days after our daughter Jennifer was born. I spent several more months convalescing at home before I went back to work.

'Those months in the hospital taught me a great deal. Just like every other doctor in the world, I'd always thought I had empathy with my patients. But being in the hospital showed me how much I'd been missing — the things patients need that we're so unaware of. The little things — like a smile or a touch on the arm when you walk past, a simple hello in the morning, just a nod to let him know not only that he still exists but that he's still important.

'Without those things, the patient feels alone and afraid, and really no longer human. You have to remember that a critical illness is a devastating experience, emotionally and physically, that the patient has to endure when he's least able. He needs your sympathy. If you find yourself becoming irritable, dispassionate, or hardboiled, be honest about it and admit that you need a respite from intensive care nursing.

'I also learned the supreme importance of listening to what the patient has to say. Okay, so maybe doctors and nurses have more medical training. But after all, the patient's the one who's living with the problem, who's dealing with it every minute. There's always the chance that he's noticed something we haven't, that he's right when he says something's gone awry. A simple check doesn't take much time and never hurts. Remember that the patient is helpless.

5. RACIAL BARRIER. Certain racial groups regularly have lower income and educational levels than the average. In addition, racial prejudice has often meant denial of ready access to first-class medical care to minority groups.

6. GEOGRAPHIC BARRIER. Long distances and poor roads often impede access to medical care in rural areas. But geographic barriers can be just as great in the urban ghetto where transportation is often not available though distances are short.

Examples of provider-related barriers are the following;

1. LACK OF FACILITIES AND MANPOWER. The doctor shortage has been a problem in this country for many years. In addition, similar shortages exist for other health personnel. An added problem is the lack of uniform distribution of existing manpower and facilities. A glaring example is the shortage of extended care facilities and facilities for the elderly.

2. OPERATIONAL FEATURES OF SERVICES. The physical and operational features of many medical facilities, especially for the poor, often discourage their use. Such aspects as inconvenient clinic hours, long waits, and dehumanizing treatment make comprehensive care hard to find. Such facilities tend to meet only basic needs of acute illness.

3. FRAGMENTED CARE. Fragmentation of health services is a severe problem for the poor, but also for others. Patients without a family doctor often see many physicians for a given illness and never receive comprehensive evaluation or care.

THE CASE HISTORY OF ROSA LOPEZ

Rosa Lopez is a 24-year-old Puerto Rican woman living in Tackytown, Pa. with her husband and two-year-old daughter. She began to feel sick in April, suspected that she was pregnant, and went to a neighborhood spiritualist for help. He gave her a plant to eat and said that her pregnancy would be confirmed if menstruation did not occur within a week. The plant told her that she was indeed pregnant; she continued to feel very weak, was unable to eat, and was bleeding vaginally.

A visiting nurse took Rosa to see Dr. Wasp, a private physician in Tackytown, who confirmed her pregnancy, examined her, and told her to go to the clinic at Budco General Hospital where she could be treated as a charity patient. She went once, but did not keep subsequent appointments made for her at the clinic. Rosa offered varying explanations for her missed clinic appointments to the visiting nurse and the Spanish Social Worker. Sometimes she said she was too sick and just wanted to be left alone. Sometimes she complained about the distance to Budco, which was in the next town and required two transfers on public transportation; each trip involved either lengthly babysitting arrangements for her daughter or a long and tedious trip together. At other times Rosa felt frightened of the doctor, embarrassed by the exam and the questions, ashamed to discuss her symptoms, and afraid that people would make fun of her poor English. She did not take the pills she was given because she did not believe that medicine helps the body become well. She felt that if the body wants to become well, it will do so on its own.

Dr. Wasp had contacted the social worker to make followup appointments, but Rosa broke them all. He had detected cancer in situ of the cervix on his office Papanicolaou smear, and believed that Rosa should be treated promptly both medically and surgically for her condition. She was not informed of this development. Rosa refused all medical treatment except from the spiritualist until she was too weak to get out of bed. Then the spiritualist suggested that she see the doctor. Rosa

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called the social worker, who called Dr. Wasp, and was told that he would make no more appointments for her since she had broken so many. She then went to the emergency room of Tackytown Hospital, where she was told by the nurse that, since she was registered at the Budce General Hospital Clinic, she should return there. She did, and was admitted to Budce for two days of tests. She was then discharged, and told to report to the clinic each week until the baby was born, and to try to gain some weight. At the time of her discharge, Rosa weighed 80 pounds.

Three days later, Rosa was rushed back to Budce in an ambulance. She delivered a four-pound baby boy, about two months premature. She was discharged after five days, told to rest at home for six weeks, gain some weight, report to the clinic each week, and then return to the hospital for an operation to correct her condition.

Four days later she again became acutely ill, and was taken by her husband and the spiritualist to the hospital. She left after two days, saying that too many people were examining her and she missed her children. She did not keep her post-partum clinic appointments and was next seen in the emergency room three weeks later, having hemorrhaged at home. A complete hysterectomy was performed, and she was discharged three days later with instructions to keep off her feet for three weeks and report weekly to the clinic. She did not come to the clinic again; she and her two children returned to Puerto Rico the following month.

QUESTIONS FOR DISCUSSION

1. What factors prevented Rosa from seeking care?
2. What factors prevented Rosa from getting good care?
3. Was anyone able to help Rosa? How?
4. How could the health care system of Tackytown deal more effectively with patients like Rosa?

DEATH AND DYING

Some physicians are unhappy about the pressure they feel from their colleagues, the hospital, and families of patients to prolong life when death in a short time is inevitable. One such physician is quoted;

> The dying patient should be treated with dignity. It has always bothered me that our job as doctors is not to alleviate suffering but to prolong life. We're almost forced to do everything in our power to prolong life. We're doing it in the hope that maybe a miracle will occur. We throw people into oxygen tents; we do all sorts of heroic things. We even rip open chests and squeeze hearts of patients who have massive myocardial infarctions or cancer involving their hearts. Everything is justified to save the life of a salvageable patient. But where death is inevitable I wonder if it isn't the best thing to make them comfortable and leave them alone. Usually we don't. I become impatient with those who think first and foremost of the health of the body and never think about the soundness of moral fortitude and the soul within the golden vessel known as the human body.

Other questions with which physicians struggle in treating dying patients include the following;

1. To what extent should misrepresentations, evasions, half-truths or untruths be used to "protect" the patient and/or the family?
2. How far should the disease be treated?
3. Should the doctor discuss with the patient the meaning of his symptoms if the patient asks? If the patient doesn't ask?

THE CASE HISTORY OF MARIA LUCHERT

Maria Luchert, a twelve-year-old girl, was brought to Eastern University Hospital by her parents at 3 A.M. on January 12 in critical condition. She was terminally ill with leukemia; this was her first hospitalization. Her father expressed his wish to the intern and resident that nothing be done to prolong her life, but only to make her comfortable until the end. She was admitted to the service of Dr. Bland, a noted pediatric hematologist who is conducting an extensive clinical research program on leukemia patients. The intern assured Mr. Luchert that Maria would get the same high-quality care as all patients on the service, and proceeded to institute measures to ameliorate her acute life-threatening condition. She responded well, and looked much better by the time Dr. Bland arrived in the morning for rounds.

Maria was routinely started on the standard regimen consistent with Dr. Bland's treatment, and continued to improve. Her parents, especially her father, seemed bewildered by her condition. Mr. Luchert repeatedly told everyone on the staff that he wanted no dramatic or extreme methods used on his daughter. He was overheard telling his wife that Maria's hospitalization was a mistake; he had consented to it only because he was sure she was dying. As Maria continued to respond to her therapy and her condition improved, she became everyone's favorite patient. She was cheerful, bright, and alert; her frequent questions about her condition and the possibility of her death were dismissed routinely by the staff as "nothing for you to worry about - you're getting better".

On February 2 shortly after evening visiting hours were over, Maria had three grand mal seizures, developed a generalized rash, and was unarousable to all stimuli. The intern and the nurse worked through the night instituting emergency measures, but Maria's coma persisted. During their efforts to reverse her condition, she was intubated and maintained on a respirator. The nurse was reluctant to participate in these

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procedures, and so expressed herself, but the intern ordered her to comply. Mr. Luchert arrived at the hospital early in the morning because he "had trouble sleeping". He was enraged at the sight of his daughter "with tubes coming out of her and going into her - a living vegetable." He screamed at the doctors and nurses, physically attacking the intern. He demanded that the intern remove all the tubes and let Maria die in peace. The intern refused. Dr. Bland was called.

QUESTIONS FOR DISCUSSION

1. What are the most important problems in this case?

2. Why did the intern behave as he did?

3. What do you think Dr. Bland will do?

PATIENT INFORMATION

Name: Barney Timmons Date: 8/14/72 Time: 4:45 p.m.

REASON FOR HOSPITALIZATION OR CHIEF COMPLAINT: Left anterior chest pain (onset while walking), vomiting; profuse sweating
DURATION OF PROBLEM: Since 1:00 p.m. this day
OTHER ILLNESSES AND/OR PREVIOUS EXPERIENCE WITH HOSPITALIZATION: Myocardial infarction in 1968; exertional angina since then; hypertension diagnosed in 1969. In hospital for previous MI, 1968.
OBSERVATION OF PATIENT'S CONDITION: 66-year-old white male, is lethargic. Experiencing moderate degree of pain. Slightly obese for body build--185 lbs., 5'6" B/P 130/90; pulse 65. Resp. 24. Pedal edema noted
MENTAL/EMOTIONAL STATUS: Cooperative to commands Oriented to time, place, person, somewhat anxious. Hearing deficit, dx in 1970; doesn't wear aid
ALLERGIES: None
MEDICATIONS: Nitroglycerine as needed, Aldomet Q.I.D.
PROSTHESIS: None
PATTERNS:
HYGIENE: Has upper and lower dentures; showers each morning
REST/SLEEP: Retires at midnight. Averages 7 hours sleep
MEALS/DIET: No food intolerances; eats 3 meals per day Lax in following salt-free diet
ACTIVITY STATUS: Restricted because of angina on exertion
ELIMINATION: bowel--daily movement in morning after breakfast. bladder--voids 5 times daily. No nocturia
MENSTRUAL HISTORY:
HEALTH PRACTICES: Sees private physician every 4 months
LIFE STYLE: married for 30 years. Two married children. Attends Methodist church regularly--is an Elder
TYPICAL DAY PROFILE: Retired city fireman. Works in yard and garden in summer months. Enjoys grandchildren. Sports fan

PROBLEM LIST

#	Date	Problem Description

PATIENT INFORMATION

Name: Gloria Stone   Date: 6/20/72   Time: 1:00 p.m.

CHIEF COMPLAINT: Nausea and lower abd. cramping with small amounts of green liq. stool 3-4 x day. Hodgkins IV B 12/69 c/o "Esophagitis and Constipation"

DURATION OF THIS PROBLEM: 2 weeks without normal B.M. and poor appetite, weak

OTHER ILLNESSES AND HOSPITALIZATION: 12/69 Hodgkins IV B RX--1/70; radiation and chemotherapy 1970-1972; exp. lap. with splenectomy 2/70

OBSERVATION OF PATIENT'S CONDITION: 23-year-old white female, R.N., with cushingoid/appearance; distended abdomen and mild epigastric tenderness, some edema legs, Ht. 5'4"; Wt. 49.5 kg; B/P rt. arm 106/70, T. 37.6, P. 120, R. 20. No petechiae on body. Gums look healthy

MENTAL/EMOTIONAL STATUS: depressed and angry. "I was doing well until this happened now what." Quieter than usual, knows she had Hodgkins.

ALLERGIES: Compazine, "makes me hyperactive."

MEDICATIONS: Prednisone 30 mg/qd with Maalox, Darvon plain for abd. pain, Dalmane 30 mg HS PRN

PROSTHESIS: None

PATTERNS:

HYGIENE: good, bathes in evening-showers if strong enough

REST/SLEEP: only 5-6 hrs./night, retires at midnight

MEALS/DIET: appetite poor with this episode

ACTIVITY STATUS: independent in activities of daily living (ADLs)

ELIMINATION/BOWEL: constipation-diarrhea 3-4 x/day--poss impaction Bladder: 4-5 x/day--occ. nocturia "mostly when can't sleep"

MENSTRUAL HISTORY-LMP: 5/25/72--normal for her

HEALTH PRACTICES: M.D. every month sometimes oftener

LIFE STYLE: prior to 12/69--worked as R.N. in ICU. Since 1970 has only worked for 1 month--late '71 to 1/72

TYPICAL DAY PROFILE: lives with parents and 15-year-old brother "who hates to visit hospitals." good relationship with parents, also has a boyfriend who "has never given up even though he knows I have a fatal disease."

PROBLEM LIST

#	Date	Problem Description

FAMILY CASE

The nuclear family continues to be the most basic unit of social organization in the United States. Wide differences, though, do occur in family structure and dynamics given various class, racial, and ethnic backgrounds. Consideration must be given to these differences by health professionals.

Within the last five years, family practice residencies have begun in many hospitals across the country with physicians in this specialty to replace the general practitioner. The intent of family practice is to provide full primary care to each member within the family context. The growing literature from the mental health sciences on the family and family therapy has given emphasis to the etiologic factors for both emotional and physical aspects of disease and to the necessity for considering the family context for treatment and management of the patient's case.

The following case highlights how the complexities of the family affect the medical care process. It also demonstrates the necessity for the assessment of the total patient within the family context.

THE CASE OF SARAH REILLY

Sarah Reilly is a 35 year old married female. She has been complaining of multiple joint pains of two years duration. Her symptoms had been under fairly good control with high doses of aspirin. Recently, Sarah has had increasing swelling, pain, and limitation of motion of the left knee, and is no longer comfortable with aspirin therapy. She has been hospitalized. Her physician finds no marked changes in her pathophysiology; Sarah feels that surgery is indicated for her increasingly severe symptoms which make her unable to function in her role as homemaker and mother.

The patient is the only child of Jewish immigrants, and was raised in an extremely protective, solicitous environment. She describes her childhood as very happy, and says that she was always given whatever she wanted, although her parents were not financially secure. Sarah's parents wanted very much for her to attend college and become a teacher; they were distraught when she chose instead to marry John Reilly, her high school sweetheart. There followed a period of estrangement between Sarah and her parents, who had formerly been extremely close. The parents disapproved of John because he was not Jewish, because he did not attend college, and because his job as a policeman was not one they respected.

Sarah's father died two years ago after a long illness which depleted the financial resources of the parents. Her mother, forced by loneliness and financial dependence to reconcile with Sarah, lives with the Reillys. She suffers from colitis and has been depressed since her husband died. The mother is described as demanding, helpless, and guilt provoking.

John Reilly, age 38, suffers from frequent headaches and high blood pressure and may be placed on disability. He is described as a devoted family man, very patient with his children, and willing to help everyone. Sarah says she has never seen her husband angry.

There are three children: Mary, age three, whom Sarah calls "the baby", cannot feed herself, is not toilet trained, and cannot talk in sentences; Margaret, age 6, was well-developed and in good health until her mother's hospitalization, when she developed stomach pains and refused to go to school; John, Jr., age nine, is in good health, doing well in school, and extremely responsible at home.

QUESTIONS

1. How would you evaluate Sarah's medical problems?
2. What would be your assessment of Sarah within the family context?
3. What treatment plans would you consider?

DOCTOR-PATIENT RELATIONSHIP

The tendency for people to judge each other by what they ought to do, rather than to try to understand what they are doing, is often present in the doctor-patient relationship. Rather then perceiving patients as they are, the health professional views the patient according to preconceived attitudes of how "good" patients should behave. This tendency toward moralistic judgements rather than understanding based on fact and reason will impinge severely on the doctor-patient relationship. Without eliminating values from the therapeutic relationship, the health professional must strive for insight into the influence of values, how they are acquired and used in structuring social relationships. Thus, the stereotypes of the "good" patient (who is cooperative, unquestioning, compliant, grateful) and the "bad" patient (who is belligerent, does not follow orders, questions the knowledge of the health professional, or calls the doctor frequently at inconvenient times with irrelevant or trivial questions) may be broken down and replaced with an attempt to view each patient, as an individual, to be understood and helped in the context of his/her own value system.

THE CASE HISTORY OF STELLA PAGANO

Stella Pagano is a 55 year old Italian-American female. She is 5'4" tall, weighs 180 pounds, and has a 25 year history of diabetes mellitus. She has been treated in the clinic of University Hospital for her disease for the past 23 years. On January 3, Mrs. Pagano was admitted from the emergency room in congestive heart failure. This is her fourth such admission. There is no mystery about her physical condition or the requirements for the management of her illness. She has always tolerated insulin well and is faithful about taking her medication. However, maintaining her diet properly to control her diabetes is a chronic problem to the medical and house staff.

On this admission, she revealed that she had eaten a large meal of spicy Italian food heavy in carbohydrates the night before her present attack. She admitted realizing that this food violated her prescribed diet, but explained that the family celebrated the marriage of a niece at her home which made it impossible for her to restrain herself. Dr. Schmidt, a resident in internal medicine who has followed her in the clinic during the past year, grew very impatient. He had heard similar stories from Mrs. Pagano each time she came to the clinic. As he leafed through her chart, he saw numerous notes from similarly exasperated physicians year after year denoting frustration and disgust with Mrs. Pagono's lack of motivation to control her diet.

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Mrs. Pagano is extremely friendly and jovial, and always generates a feeling of warmth among the clinic staff, even as they are scolding her for neglecting her diet. She often arrived at the clinic with a fresh-baked cake or batch of cookies, and always brought with her the latest snapshots of the newest grandchild or son-in-law. She obviously enjoyed a central role in her large family, which consisted of her husband, four brothers and their families, five grown children, their various spouses, and 12 young grandchildren. One unmarried son and one married daughter and her husband and two small children live with Mr. and Mrs. Pagano. This daughter works during the day while her husband attends law school. Mrs. Pagano cares for the children and prepares all the meals for this large family. She reports that there is almost always company for dinner, as all her children and her brothers live in the same neighborhood and maintain an extremely close family relationship. According to Mrs. Pagano, everyone is busy and separated during the day, and they look forward to dinner as the time to be together and enjoy each other.

At her discharge on January 10, Dr. Schmidt curtly and brusquely informed Mrs. Pagano of the dangers of neglecting either her diet or her medication. She cheerfully accepted his recommendations and agreed to cooperate, as was her usual reaction. In fact, she had never successfully carried out the doctor's orders from one visit to the next. Following this discharge, in a new experimental program, a fourth-year medical student named Michael Donatetti was assigned to her case to follow her on an outpatient basis. Mr. Donatetti saw Mrs. Pagano several times in the outpatient clinic and visited her at home on three occasions.

Six months later Dr. Schmidt saw Mrs. Pagano again at the clinic. For the first time in her long history, Mrs. Pagano had maintained her diet and was able to reduce her visits to the clinic. A feeling of confidence seemed justified that she would continue with the requirements to manage her medical problem. She was cheerful and pleased, but no more so than on previous occasions. She seemed unimpressed with Dr. Schmidt's pleasant surprise at her progress, especially her loss of 18 pounds. In fact, Dr. Schmidt noted that she seemed less eager to please him, seemed to listen less carefully to what he said. Nevertheless, two years later, Mrs. Pagano continues to be a well-controlled diabetic. She now weighs 150 pounds, attends the clinic only every three months, and has had no further hospitalization.

QUESTIONS

1. What was happening in the interaction between the patient and her physicians?
2. Why was the early treatment so ineffective and what happened to change her behavior?

FINANCIAL IMPACT CASE

The cost of medical care in America has been escalating dramatically over the last two decades to now $118.4 billion, 8.3 per cent of Gross National Product. The spiraling inflation of physician fees and hospital care costs have presented significant problems to a growing proportion of the population who can't afford "to get sick".

Ability to pay for medical care in many ways depends on insurance. Most working people in the United States have either Blue Cross - Blue Shield hospital and medical insurance or some other form of private insurance from a commercial insurance company. To these people the level of insurance benefits; the amounts of deductibles and co-payments; and the service exclusions from coverage all affect their "out of pocket" costs. The federal government provides insurance for a portion of the aged's medical care (Medicare) and a portion of the poor's medical care (Medicaid). The unemployed population, almost as a whole, has no medical care insurance.

Most insurance plans still do not cover physician care rendered in an office or clinic. Therefore, seeking medical care has an economic barrier to the office physician visit. Physicians more and more are finding patients do not have the money to pay their fees, and this affects the patient's health and well being.

CASE

Mrs. Holmberg, a forty year old woman, came to clinic with the symptoms and signs of a very obvious hyperthyroidism. After laboratory data confirmed the clinical impression, she was treated with a therapeutic dose of I-131.

Her husband, a chronic invalid with severe pulmonary emphysema, requires hospitalization every few months and was virtually unable to work. The couple lived on what they could earn as janitors for three tenements. They had no other financial resources. Since they were not employed by any firm to offer them health insurance, they had only a policy which paid a small amount per day for in-patient care only. Neither the husband or wife had any family or friends.

The patient feared and disliked her employers. The salary barely paid for food. The hospital bills of the husband had amounted to over $[illegible],000. In addition, she was chronically depressed, anxious and tense.

QUESTIONS:

1. Provide an assessment of the total patient.
2. What is the physician's responsibility in caring for this patient?
3. What help can the physician secure from the clinic social worker?

Case 1 Special Patient Problems

A 54 year old bank manager with the history of maturity-onset diabetes mellitus, mild diastolic hypertension; who had been managed as an out-patient with a low salt diet and SER-AP-ES (reserpine 0.1 mg; hydralazine hydrochloride 25 mg; hydrochlorothiazide 15 mg) one pill T.I.D., is admitted to the Coronary Care Unit with the classic findings of an acute myocardial infarction.

The patient is married and has three children (ages 20, 16 and 11). On admission to the unit he is observed to be very apprehensive and exhibits marked motor restlessness. When the staff reassures him that they will look after him and help make him comfortable, he responds by saying, "There's really nothing wrong with me! You're just like my wife - always overreacting and getting upset; just call my office and tell my secretary I'll have the report due today back to her tomorrow".

During the first hospital day the patient is restless and frequently triggers the monitor warning system. He has told his wife not to bother coming to visit; he's fine; and will call her daily.

Questions:

1. What are the problems in this case?
2. What additional information would you want?
3. What are the emotional reactions of people in your culture to myocardial infarction? How do these compare with reactions you might expect here?
4. How would you manage this patient in the CCU? After he leaves the hospital?
5. During this patient's hospitalization would you inquire about this patient's sexual relationship with his wife? When would you do this? How?

Terms

Anxiety - "apprehension, tension, or uneasiness that stems from the anticipation of danger, the source of which is largely unknown or unrecognized. Primarily of intrapsychic origin, in distinction to fear, which is the emotional response to a consciously recognized and usually external threat or danger ... May be regarded as pathologic when present to such an extent as to interfere with effectiveness in living, achievement of desired goals or satisfactions, or reasonable emotional comfort."

ICU psychosis - psychologic reaction of severely ill patients in critical care settings in which agitation; disorientation; paranoid delusions are prominent features.

Denial - a defensive psychologic mechanism, operating unconsciously, used to resolve emotional conflict and allay anxiety by disavowing thoughts, feelings, wishes, needs or external reality factors that are consciously intolerable.

The attached selection should be read before the case. It was taken from, TALKING WITH PATIENTS by Brian Byrd, M.D. (Philadelphia: J. B. Lippincott Company, 1973).

CASE

A new resident, Dr. Nodd, had just been assigned to the medical clinic at County Hospital. Medical staff supervision of the clinic was woefully inadequate. The caseload required the resident to spend less than five minutes per patient.

A 69 year old woman, Mrs. Frank, came to the clinic complaining of shortness of breath. The symptom had been troublesome for about a month before this visit and was getting steadily worse. She could climb the three flights to her apartment only very slowly and with great distress. She was, therefore, almost totally confined to her rooms. During the interview, she sat quietly, seemed to be brooding and was loath to talk. Harried and anxious, Dr. Nodd did not obtain a complete medical history.

Physical examination showed the classical symptoms and signs of mitral-insufficiency and congestive heart failure. In addition, she was moderately obese and seemed sad and depressed. Her hospital records stated that the diagnosis mitral-insufficiency had been made fifteen years before, but she was then well-compensated. She had not attended the clinic for almost eight years and had had no cardiac symptoms until recent months.

Dr. Nodd wondered why heart failure had appeared at this time. On further questioning, he learned that she had been eating a lot since her husband's death seven months before and had gained over thirty pounds. Her husband had been a chronic cardiac invalid for many years, living on a low-caloric, very low-sodium diet. She had been his devoted nurse and had lived on the same diet. Deeply depressed after the death, she began to eat more and more. As her weight increased, it became increasingly difficult for her to leave home. As her activity decreased, her depression increased.

Rushed to see the long line of patient waiting, Dr. Nodd felt he may not have the ability to help this woman.

QUESTIONS:

1. List the treatment goals and plans for Mrs. Frank.
2. What must Dr. Nodd do to assure full and proper care for the patient?
3. What resources are available to Dr. Nodd to care for the total patient?

MD's Revolt

the doctors' own fault," said San Francisco obstetrician Dr Frederick Ostermann. "For years doctors went around telling government to leave them alone. And then the first time they're in real trouble, they start yelling for government to help them."

In a last-minute attempt to fend off the doctors' strike scheduled to start over the weekend, the New York State insurance commissioner granted a license for the medical society's own insurance underwriting company. But many physicians were reluctant to join such a venture, on the ground that without fundamental changes in malpractice adjudication, even their own insurance company would be unable to offer protection at reasonable rates. At one point Bronx Assemblyman Thomas Culhane introduced a bill to revoke the license of any doctor who refused to treat a patient

For the moment, the prospect was that still more doctors' strikes might be in the offing nationwide. Anesthesiologists in San Antonio went on a slowdown over new increases in their insurance-premium rates, and orthopedic surgeons in Rhode Island announced that they were considering a strike on June 9. In at least 30 states, legislators were working to hammer out solutions to the malpractice problem. And if all else failed, there was a strong chance that the Federal government might have to enact laws of its own—despite the avowed determination of the Ford Administration to leave the solution to the states. "Fully one-third of the nation's health bill is paid for by the U.S. Government," said Eli P. Bernzweig, a former insurance-company vice president. "Unless the states do something quickly, the government is going to have to step in."

How did the malpractice problem achieve such crisis proportions in so short a time? While there are many causes of the problem, the most immediate is the almost geometric progression in the number of malpractice claims against physicians—and an equally steep escalation in malpractice awards. Once an uncommon occurrence in tort law, more than 20,000 malpractice claims are now brought against doctors each year and the number is rising steadily. In New York, the number of suits filed against physicians rose from 564 in 1970 to 1,200 last year. The St. Paul Fire and Marine Insurance Co., one of the nation's leading malpractice underwriters, reports that the number of claims pending against the doctors that the company insures has risen from 1 in 23 in 1969 to 1 in 10 today.

In the past decade in New York, the average cost of a malpractice claim—awarded either by judge or jury, or resulting from an out-of-court settlement—grew from $6,000 to $23,400. Even more dramatic, however, has been the sudden increase in outsize awards (page 64). Until last year Chicago had never seen a malpractice judgment larger than $250,000 against a physician. Since then, three awards in excess of $1 million have been brought against Chicago doctors, including one that totaled $2.5 million. In California, there were only five judgments or awards for more than $300,000 in 1970, but in 1974 there were 36. Of the nineteen settlements or awards of more than $1 million in the state's entire history, thirteen have come during the last 28 months.

The escalation of costs has been inevitably paralleled by increases in the premiums doctors must pay for malpractice coverage. After a doubling of their premiums a year ago, New York physicians now pay from $776, if they are in low-risk

Dan Bernstein

The operating room: A surgeon who takes a risk may be sued specialities such as psychiatry to $14,329, if they are in such high-risk fields as orthopedics, anesthesiology and plastic surgery. In Cleveland, the average premium rose from $2,300 in 1972 to $4,000 in [illegible], with specialists paying as much as $30,000 a year. One Miami obstetrician paid $3,500 for insurance when he opened his office a year ago; this year, his insurance will cost $11,000. "If my training had taken one year longer," says the 34-year-old physician, "I could not have gone into business."

Not surprisingly, the conflicting attempts to assign the blame for this unhappy state of affairs has put the doctors at loggerheads with the trial lawyers. Among the major points of contention from the physician's point of view is the contingency fee, by which a lawyer takes a case with the understanding that he will receive from 30 per cent to as much as 50 per cent of the award if he wins—and nothing if he loses. This arrangement, the doctors argue, simply encourages patients to sue whether they have a valid case or not.

The lawyers disagree. "The contingency fee," says Charles Kramer, senior partner of a New York firm that probably handles more malpractice litigation than any other in the world, "is the average man's key to the courthouse. Without it, he could rarely afford to pay a lawyer to handle any kind of injury case." Kramer says that the medical profession's desire to abolish the contingency-fee system is just a means of preventing aggrieved patients from getting the services of a first-rate lawyer. He adds that good lawyers don't take frivolous or unworthy cases. Kramer estimates that his firm rejects nine out of ten potential litigants, sometimes over a legal technicality such as the expiration of the statute of limitations, but more often because he and his colleagues decide that no malpractice was involved.

The cases that Kramer has taken to court have twice brought awards of $1 million or more and qualified him to join the Inner Circle of Advocates, composed of liability attorneys who have won such amounts at least once. The first of the cases involved a mother of four who had undergone a hysterectomy in a New York hospital. When she complained of pain after the [illegible] shot of morphine that triggered a toxic reaction. This, Kramer explains, could have been quickly controlled by administration of the antidote, Nalline. However, the hospital staff delayed giving the drug, and finally used the less speedy intramuscular route. As a result of the delay, the patient became totally blind and paralyzed on her left side. "I place at the feet of doctors," says Kramer, "all the problems of malpractice. Patients aren't getting the kind of care they should be getting."

[illegible]

Physician Blackman: He blames lawyers

But Dr. Norman S. Blackman, president of the Kings County, N.Y., Medical Society, responds that much of the blame for the current trouble rests squarely with the legal profession. "Lawyers," he says, "think in terms of how much it is worth to get rid of a case, not of the justice of the case."

Aurora's [illegible]

and a physician [illegible] suits. They were [illegible] with the case of a woman who [illegible] hospital [illegible] shortening of her [illegible]. Despite Blackman's [illegible] that the woman's [illegible] the other [illegible] $20,000 [illegible] this sum, he notes, [illegible] now [illegible] $1 [illegible]

A[illegible] most serious results of the malpractice crisis, in the view of most [illegible] is the fact that the threat of being [illegible] the practice of [illegible] medicine. Physicians [illegible] and X-rays [illegible] making a diagnosis [illegible] in the hospital for [illegible] easily be done. [illegible] Some experts estimate [illegible] tions [illegible] from $[illegible] the total national [illegible]. Blackman notes [illegible] "negative defensive medicine" [illegible] which doctors covertly deny treatment in cases that might result in a suit. For example, physicians have sometimes [illegible] not to resuscitate [illegible] for fear that [illegible] have occurred and [illegible] suit should [illegible] what's legally [illegible] Blackman, [illegible] what's medically [illegible].

Recent court decisions have [illegible] considerably [illegible]. In the most notable recent case, two ophthalmologists [illegible] negligent a buildup of pressure within the eye—in a 32-year-old woman whom they had fitted for contact lenses. They should have performed a pressure test on their patient's eyes, the court decided, despite [illegible]ple testimony from expert witnesses [illegible] such testing is almost never done routinely on patients under the age of 40 since the disease seldom begins until middle age. "According to this ruling," says Prof. William Curran, professor of legal medicine at Harvard University, "a physician who doesn't perform a test for a condition becomes, in legal terminology, a 'guarantor' against that condition. That's really dangerous."

Curran disagrees with lawyers who insist that malpractice is largely the result of incompetence or negligence, and that suits are the only effective method of disciplining the medical profession. He thinks, in fact, that far more cases of negligence go undetected than come to light in the courts. Most malpractice cases, he says, aren't the result of faulty doctoring but of the inherent risks of modern medicine with its rapidly developing techniques. "It's apt to be the most competent surgeon who gets sued," says Curran, "because he's doing the risky surgery."

Today's consumerist society holds that any injury must be compensated, whether due to negligence [illegible]ot; and in medicine, the malpractice suit is the only recourse. This not only contributes to the malpractice burden of all physicians but can also have dire consequences for a few of the most well-intentioned and humane among them. Three years ago, Dr. Eugene R. Balthazar, a 72-year-old general surgeon, used his life savings to open a free clinic to serve a poor section of Aurora, Ill. In doing so, he reduced his malpractice coverage to only $10,000. Now, however, he faces a $100,000 suit brought by a woman whom he treated with an electric needle for a small skin cancer near her eye and sent to a surgeon for removal of the growth. She now claims the treatment resulted in a cosmetic defect and impaired vision. If she wins, the clinic may have to close. "We're being attacked by an evil force," says Balthazar. "She is being ill-advised and exploited."

Being sued for malpractice can be a sobering experience for a physician—even if he wins the case. Dr. Thomas G. Baffes, chairman of the department of surgery at Chicago's Mount Sinai Hospital Medical Center and a pioneer in heart surgery, once repaired a heart valve in a 60-year-old patient, whose condition was complicated by high blood pressure and diabetes. The operation saved the [illegible]'s life, but when he had a stroke nine months later, he blamed it on Baffes and sued for $1.2 million. The surgeon was exonerated, but only after a four-year court battle, and he was so shaken by the experience that he made up his mind to go to law school at night. "I decided it was important to learn what lawyers were trying to do," Baffes says.

The legal training has helped Baffes a great deal in his practice. Today, he's much more cautious about trying to accomplish too much in the operating room. He makes sure his department keeps adequate records and that his colleagues establish close rapport with their patients. "We can't play God any more," says Baffes. "We have to tell our patients straight away what the risks are and ask if they want to take them."

The companies that sell malpractice insurance, of course, complain that they are being hurt just as much by the mounting tidal wave of lawsuits as are the doctors. Most insist that they are losing money at such a rate that they must either double and redouble their premium rates or go out of the malpractice business. The trouble in New York, for example, stemmed from the decision of the Argonaut Insurance Co. of Menlo Park, Calif., to pull out of the state when the doctors refused to go along with a 200 per cent rate hike. As a stopgap measure, the legislature arranged for a pool of all the insurance companies selling liability policies in the state to provide the physicians with coverage when Argonaut leaves in July. But the dissident physicians argue that even this arrangement will mean much higher premiums.

Drawing by D. Fradon; ©[illegible] The New Yorker Magazine, Inc.

'Damn! I suppose this means another malpractice suit!'

One of the main problems that malpractice insurance poses for the companies is the fact that most policies are written on a so-called "occurrence" basis. This means that the company is liable for any malpractice episode that occurs in a given year, even if the claim isn't filed until a subsequent year. Thus, the total amount of premiums received by companies reporting data to the American Insurance Association in 1966 was $13.6 million. But by 1974, those companies had paid out a total of $18.2 million in losses on the 1966 policies. This "long tail" of claims, say the insurers, makes it hard to reach actuarial estimates on which to base premiums from year to year. "It's as if a car manufacturer tried to set a fair price today for a car he would not deliver until 1980," says one insurance-company executive.

To solve the problem, some companies are insisting on a so-called "claims made" system in which they would have only to cover claims made in the same year that the alleged malpractice took place. Although the premiums are somewhat lower under this arrangement, the doctors don't like it because they are still forced to buy "tail" policies to cover themselves for suits filed after the expiration of a year's coverage.

Both doctors and lawyers question the insurance industry's version of the situation. "There's no more powerful and successful venture in all of human endeavor than insurance," says Dr. Richard F. Gibbs of the Massachusetts Medical Society. "That's because it functions on a very simple formula—cost plus profit equals premium." "The companies should be made to open their books," says Robert Cartwright, president of the American

SOME OF THE LOSERS WHO 'WON'

An estimated 20,000 medical-malpractice claims were made in the U.S. in 1974, but many of them never reached the lawsuit stage. Of those that did, approximately 75 per cent were settled out of court. Of those that were decided by a jury, more than two-thirds were in favor of the physician or hospital defendants. But among the relatively small number of actions won by the patient plaintiffs there have been quite a few awards of $1 million and upward—usually in cases where the patient suffered severe and irreparable damage. These are the cases that make the headlines—and which also play a major role in driving up malpractice premiums. Some outstanding recent examples:

Jeff Lowenthal

The Barzyckis: Too much radiation?

LOSS OF NORMAL FUNCTION

Driving alone on Christmas Eve in 1972, Leonard Tolley, then a 55-year-old dentist practicing in Lake Worth, Fla., had an auto accident that left him paralyzed in all four limbs. During the next few weeks, Tolley regained partial movement on both sides of his body, but his neurosurgeon recommended spinal surgery as the best hope for a full recovery. On Jan. 12, 1973, the surgeon performed a decompression laminectomy, a procedure designed to relieve pressure on the spinal cord.

The operation failed to help. After surgery, Tolley, who had been earning $100,000 annually, was again totally paralyzed, unable even to control his bowel and bladder functions. Last summer, Tolley and his wife filed a malpractice suit against the doctor. They charged that without the surgery, the dentist would have regained most of his normal functions. After a nine-day trial this spring with testimony from 28 witnesses—including eight neurosurgeons—the jury awarded Tolley and his wife $1,685,000. Of this amount, the neurosurgeon's malpractice coverage will pay $1.1 million; he must raise the rest himself.

THE MISSING SUCTION DEVICE

On Sept. 12, 1969, 22-year-old Stewart Duffy enrolled for classes at a Los Angeles-area college. After registration, Duffy took a ride on a friend's motorcycle and ended up in an accident. At first it appeared that his injuries were confined to his chin, a piece of which had been sliced off. When the youth arrived at South Coast Community Hospital and announced that he had no medical insurance, he was routinely given a tetanus shot and sent off to the Orange County Medical Center, ostensibly because there was a plastic surgeon on the staff of that hospital.

While repairing Duffy's chin, doctors at Orange County discovered that he had also sustained other injuries. His larynx was fractured, as well as a rib, which in turn had punctured his right lung. Subsequent surgery to repair these injuries went smoothly. But by the time Duffy was returned to his hospital room, it was evident that he had suffered major brain damage. The reason, Duffy charged later, was that during the few minutes in transit from the recovery room, a breathing tube that had been inserted in Duffy's throat had become clogged with fluids, cutting off his supply of oxygen. A suction device was supposed to take care of this fluid accumulation, but for some reason the device was missing. Today, at 28, Stewart Duffy is a quadriplegic, has double vision and cannot hold a pencil or speak. Last fall, in an out-of-court settlement, the two California hospitals and two doctors paid Duffy $1,065,000 in a lump sum.

A SENSATION OF NUMBNESS

Seven years ago, Janice Fay Barzycki was 25 and on top of the world. She adored her husband, enjoyed an active schedule of dancing and bowling and had just given birth to her first child, Nicole. Then in October 1968, Mrs. Barzycki, who lives in the Chicago suburb of Wheeling, learned that she had Hodgkin's disease. Happily, after two months of cobalt radiation, her cancer appeared to be arrested. But just to be sure, in January 1969 she started a new series of radiation treatments during which a far more powerful cobalt radiation source was placed in the machine. Tragically, the instructions on her outpatient chart were not adjusted, Mrs. Barzycki claimed, and for five weeks she received 6,000 rads instead of the 3,450 rads she was supposed to get with the new, more intense source of radiation.

Nine months later, Janice Barzycki began to experience a sensation of numbness in her legs; she started to fall down frequently. Within a short time, she was completely paralyzed from the waist down, with no bladder or bowel control and no sexual feeling. In 1970, the Barzyckis sued Chicago's Presbyterian-St. Luke's Hospital, five radiologists and a radiology technician. Last year, an Illinois jury awarded the couple $1,298,000, including $260,000 for the husband on the basis of "loss of consortium," a legal term that refers to loss of the spouse's companionship and of full marital relations.

Neal Boenzi—New York Times

Gail and her mother: Too much oxygen?

IRREVERSIBLE BRAIN DAMAGE

When Wanda Schnebly of Forest City, Iowa, gave birth to her fourth and last child, Kelly, in 1964, there was trouble right from the start. The mother has Rh negative blood and the child, who is Rh positive, was born extremely jaundiced. Tests at the tiny Forest City Hospital showed that Kelly was producing an abnormally high amount of bilirubin, a substance manufactured by the liver when red blood cells are destroyed.

Kelly's initial bilirubin reading of 18.9 suggested that he was accumulating tox[illegible]nounts of the substance and was in[illegible]diate danger of brain damage—and e[illegible] death—from Rh disease, which, though serious, can be treated.

The baby was rushed to St. Joseph Mercy Hospital in the larger town of Mason City about 30 miles away. There, a pediatrician tested Kelly again, and got lower bilirubin readings of 12, and then 10. Despite the facts that the infant's skin was bright yellow and his neck stiff and that his cry was high and piercing—all major signs of Rh disease—he was sent back to Forest City. His next bilirubin reading taken there was a shockingly high 38; Kelly had suffered devastating, irreversible brain damage. Kelly's parents charge that the solution used in testing for bilirubin at St. Joseph's had deteriorated, resulting in completely inaccurate test data.

Today, 11-year-old Kelly Schnebly is blind and deaf. His mental level is that of a three-month-old infant, and although he can move his arms and legs aimlessly, he cannot turn over. Last April, the Iowa courts awarded his family $912,000, but because of numerous legal entanglements, the Schneblys will receive a maximum of only $343,600—and their lawyers, $212,400.

COMMON MEDICAL PRACTICE

[illegible]ne of the most publicized recent m[illegible] malpractice cases was that won last March by Gail Kalmowitz of Brooklyn (NEWSWEEK, April 7). Gail was born prematurely in 1953 and doctors at New York's Brookdale Hospital used a procedure that was common medical practice at the time: they kept the 2¹/₂-pound infant in an atmosphere of highly concentrated oxygen. Two months later an ophthalmologist discovered that Gail had a form of progressive, incurable blindness called retrolental fibroplasia.

Much later, Gail's family learned that exposing premature babies to too much oxygen had been suggested as a cause of subsequent blindness as early as 1952—though it is not clear just how widely disseminated this knowledge was when Gail was born. In 1972, the Kalmowitzes filed a $2 million malpractice suit against Brookdale Hospital and the pediatricians who had attended Gail, and the case finally came to trial last March. But just as the Brooklyn Supreme Court jury was about to hand down its verdict, Gail—now a 21-year-old psychology major at Brooklyn College and almost totally blind—lost her nerve and decided to accept an offer of a $165,000 settlement from her doctors' insurance company. Then, only a few minutes later, she found [illegible] that the jury had been about to award [illegible]900,000 in damages—more than five t[illegible]es the amount she had just accepted.

—JEAN SELIGMANN with WILLIAM SCHMIDT in Miami, ELAINE SCIOLINO in Chicago and SUNDE SMITH in Los Angeles

Trial Lawyers Association. "I feel that if this were done, we'd find their claims are spurious." Prompted by just such suspicions, California and possibly other states will investigate the bookkeeping of malpractice underwriting firms.

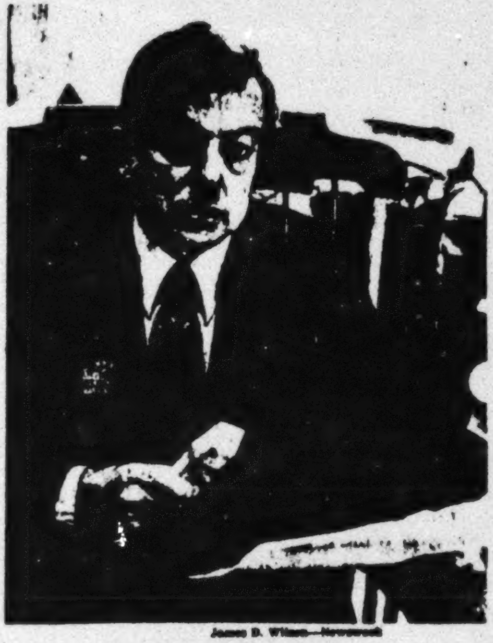
Meanwhile, the desperate search for solutions to the malpractice threat has turned up a wide range of promising notions, but no firm answers. One of the best ideas, according to Harvard's Curran, would be a nationwide nonprofit plan, with no scaling of premiums according to specialty. This is the way it's done in both Great Britain and Canada. In England, for example, doctors pay about $60 a year, and in Canada, $100 for coverage. Although the number of suits has risen in both countries, the volume doesn't approach the U.S. level. Among the reasons is that contingency lawyer's fees are seldom allowed in Canada and are expressly forbidden in Great Britain; with few exceptions, malpractice trials are held before a judge and not a jury in both countries.

Another key measure, according to David Rubsamen, a Berkeley, Calif., physician-attorney, is to put a ceiling on malpractice awards and institute more sensible means of paying them. "How does one place a value on an injury that removes hopes for a normal life, anyway?" he asks. "Any figure is an absurdity." Rubsamen thinks that compensation from sources other than the suit, such as workmen's compensation, should be disclosed at the trial so that it can be taken into account in arriving at a judgment. He also proposes that awards to cover future medical costs should be paid in monthly installments rather than in a lump sum. "This way," he says, "if the disability becomes more serious, the patient won't run out of money. And if the patient dies, the relatives won't get a windfall." Finally, Rubsamen favors a scale on contingency fees—the higher the award, the smaller the lawyer's percentage.

In the blizzard of legislation devised so far to solve the malpractice problem, the law that has come closest to satisfying the doctors is the one enacted in Indiana this spring. The most important provision is a $500,000 ceiling on damages. Doctors are liable for no more than $100,000 in a suit, with any amount in excess of that coming from a state fund bankrolled by physicians and hospitals. The physician pays from $1,000 to $5,000 for his regular coverage, plus a 10 per cent surcharge for the extra coverage by the state. If for some reason a doctor can't get insurance from a private company, the state will cover him.

Under this law, all claims are investigated by a screening panel of three doctors and a nonvoting lawyer. While opinion is not binding, it is admissible in any subsequent trial so that a jury may take it into consideration. The law also places a two-year statute of limitations on suits by adults, but permits suits to be brought on behalf of children anytime up to the age of 8. Finally, claims will no longer specify the dollar amount of damages sought, but ask only for a "reasonable" award. "That," says state Sen. Adam Benjamin Jr., who drafted the final version of the bill, "is to get away from front-page headlines."

While many doctors see themselves as the prime victims of the malpractice crisis, they acknowledge there are also plenty of times when the patient does have a good case. Privately, they admit to being appalled by the carelessness and downright incompetence of some of their colleagues. This is reflected in the increased willingness of physicians to testify on behalf of plaintiffs in defiance of the old conspiracy of silence.


James D. Wilson—Newsweek

Rubsamen: Some figures are absurd

American Medical Association president Dr. Malcolm Todd frankly admits that 5 per cent of U.S. physicians are incompetent, and recent AMA publications have warned members about the appreciable increase of narcotics addiction, alcoholism and mental illness among doctors. Todd has urged local medical societies to be more aggressive in the discipline of repeated malpractice offenders; to see that hospital privileges are curtailed and that licenses to practice are revoked where necessary. Just as important, Todd urges his colleagues to re-establish in the era of increasing specialization and burgeoning medical technology better relations with their patients. "Every doctor," he says, "should be a personal physician."

—MATT CLARK with MARIANA GOSNELL and DAN SHAPIRO in New York, and HENRY McGEE in Washington, SYLVESTER MONROE in Boston, MARTIN WESTON in Chicago and WILLIAM J. COOK in San Francisco

CHAPTER 2

THE THERAPEUTIC RELATIONSHIP: II INTERVIEW SKILLS

CHARLES L. BOWDEN, M.D.

TYPES OF DOCTOR-PATIENT RELATIONSHIP
INTERVIEWING SKILLS
  Opening the Interview
  General Guidelines Regarding Questions and Instructions
    Bodily Locations
    Quality
    Quantity
    Chronology
    Setting
    Aggravating and Alleviating Factors
    Associated Symptoms
    Instructing the Patient
    Additional Guidelines
    Caveats
  Special Techniques
    Maintaining the Flow
    Confrontation
    Communicating Empathy
    Family Interviewing
  Closing the Interview

The fundamental characteristic of the doctor-patient relationship is the need of the patient to be able to place himself under the care of the physician, with complete trust and confidence. Part of this, of course, comes from the patient's response to such things as diplomas and office atmosphere. More important is that the physician display the characteristics previously described in the social role of the physician. Continuity of care within the therapeutic relationship allows for the building of new information on an old foundation and increases the implicit emotional support in the relationship. The therapeutic relationship is a flexible one, both in nature and depth of contact. As previously discussed, some visits may be made for an annual physical examination or for help for a minor disorder, whereas at other times the contact may be frequent and require detailed exploration of the patient's physical and personal life

Types of Doctor-Patient Relationship

Szasz and Hollender have usefully described three modes of doctor-patient interaction. The first of these is the *active-passive* mode. In it the physician uses all of the authority inherent in his role, while the patient does not actively participate in his treatment. It is generally applicable to emergent situations, such as the care of a severely injured auto accident victim.

The *guidance-cooperation* mode is one in which the physician still exercises considerable authority, but the patient is expected to cooperate, with the effectiveness of his active cooperation being a factor in determining the outcome. This mode is most appropriate to a number of acute diseases, such as pneumonia, and to the recuperative phase of most surgery.

In the *mutual participation* mode the patient is expected to be actively responsible for his treatment. The physician works in a collaborative way with the patient and must use persuasion, not his authority, to obtain the ends both he and the patient desire. The degree of dependence of the patient on the physician is much less in this type of relationship than in the other two. Some dependence is useful and normal in emergent and acute disorders. But, in general, the physician should encourage the patient to take as much responsibility as is appropriate to the kind of disorder and to the stage of treatment. The best physician is able to move freely among these three modes as the situation changes. The mutual participation model is especially important in diagnostic interviewing and in the management of chronic disorders.

In the last analysis, patients with chronic diseases must largely be their own physicians. Many studies document the high degree of noncompliance in such disorders as diabetes, hypertension and schizophrenia. Two important, related reasons for this are that physicians tend to neglect education of the patient about his disorder and its management and that they tend to assume a more authoritarian role than circumstances warrant. This is in part a result of clinical learning as a medical student, which predominantly occurs in inpatient settings dealing mainly with the acute phase of illnesses and with serious disease management.

In the 20th century several other factors make the importance of the mutual participation model greater. First, the "crowd" diseases, such as plague and typhoid fever, have largely been eliminated as a result of epidemiological medicine. The infectious diseases have, likewise, largely come under wide control through a combination of public health measures, vaccination and antibiotics. Thus the major medical concerns of 20th century man are the chronic diseases, which are multifactorial in origin (with stress a significant factor), and, with our increased longevity, diseases related to the aging process, such as heart disease, stroke and cancer. Second, although doctors 50 years ago had about as much education as they now do, most of their patients had much less than a high school education. That education gap has narrowed greatly. And the gap is likely to be less with the average patient in office practice than it is with those encountered by the medical student.

Interviewing Skills

Within the doctor-patient relationship the single most important activity of the physician is his talking with the patient. Much of the data in the rest of this book will help the physician to determine interview strategy on the basis of the person's stage in life, his personality and the particular situation in which the interview is occurring. Before that, there are basic skills which apply to most medical interviews.

Opening the Interview

Begin by asking about the problems which brought the patient to the physician. Appropriate first questions are "Tell me about the problems you have been having" or "What are the troubles which bring you in today?" Such a beginning tells the patient that you are interested in him and his problems and encourages him to discuss anything which he feels may be important. It allows the physician to learn quickly which problems the patient considers most important and gives him information about the way the patient approaches his problems—whether he minimizes, exaggerates, rationalizes or circumstantially evades the real issues. It also says to the patient that the physician wishes him to take as much responsibility and initiative in his own treatment as is compatible with good patient care. This approach to interviewing minimizes bias, which can easily be introduced when questions are detailed and directive. Let us briefly consider the most polar alternative approach to medical interviewing: the interrogative-directive, or the "district attorney" type. This approach is to ask a large number of specific questions, the answers to which are usually brief or are simply yes or no. This approach does not encourage the patient to amplify his responses; rather, the amount of information is largely predetermined by the way the question is asked. Such questioning says to the patient, "I'm in control, you follow my lead." It suggests a rather passive role for the patient. The patient may be so distracted by the rapid-fire questions that he forgets to report important symptoms, or he assumes that the physician is not interested. Some medical situations call for this authoritarian type of interview (for example, the emergency room interview of a patient in acute pain).

The interview should proceed with the patient telling his story in his own words. This minimizes bias which can be interjected when the words are chosen by the physician in a directive approach. If the patient is having difficulty in going on with his story, several facilitating comments may help. The physician may say, "Tell me more about the pain in your chest," or "You were saying about the pain in your chest," or he may simply repeat in an expectant manner the last words the patient used, suggesting that he continue on the subject "... pain in the chest."

The more general, open-ended the question the better, especially early in the elucidation of an area. For example, in obtaining a family history, the first question or request should contain only enough information to make clear the subject on which the patient is expected to respond: "Tell me about your parents" is thus a better statement than "Tell me about your mother," as it allows the patient to select which person he will talk about and it may provide information about the way they inter-relate. "What is the pain like?" is a better question than "Is the pain sharp or dull?"

As the interview progresses, specific questions will be called for both to fill in areas of the history which the patient has not covered and to complete the data needed in a particular area. As a rule, move from general, open-ended statements to specific, delineated ones. Do not accept a statement until it is as clear as possible. If a patient states that he is "nervous," one should not accept the statement as sufficient but should inquire how he experiences his nervousness.

General Guidelines Regarding Questions and Instructions

In assessing the patient's problems, the following areas are covered.

Bodily Locations. Most complaints can be localized to a specific portion of the body. Even many emotional complaints, such as nervousness or fear, are usually experienced in portions of the body. Only a few sensations are not localizable and those, such as hunger, joy, anger and sleepiness, do not hamper the characterization of the experience for diagnostic purposes. Inquiry to localize problems can be initiated with questions such as "What part of your head hurts?," or "Where did you feel the nervousness?" or "Does the pain go anywhere?"

Quality. Complaints are characterized as acute or chronic, as sharp or dull and by analogy, such as the pain of myocardial infarction being "like having one's chest crushed," or dyspnea being "like" suffocation. Inquiry in this area is best begun by asking, "What was it like?" If the response is unclear, a statement such as "What do you mean by 'gripping?' " or "Was it sharp, or dull, or aching or what?" can be helpful.

Quantity. The quantitative aspect refers to the intensity of the stress perceived (mild to unbearable), the degree of functional impairment (usually based on a description of everyday activities) and the frequency, volume, number and size of symptoms.

Questions concerning intensity are best framed in personal and comparative terms. The query, "How severe was it?" encourages the patient to elaborate in personal terms. Similarly, the question "Was this the worst it has ever been?" or "How would you compare this with your spell a year ago?" provides an estimate of severity.

Questions which get at functional impairment are best asked concerning everyday tasks: "Are you able to do your housework?," or "Can you fully dress yourself?" or "How far can you walk before you get short of breath?" An especially useful source of data in this and several areas of inquiry is to ask the patient how a full day went for him, starting with when he arose and what he then did in a step-by-step fashion throughout the day until he retired. It is best to ask about a specific day, usually the one before the day of examination, as the response will yield more vivid, clear-cut information. Many physicians will wish to record this as a separate part of the work-up in the problem-oriented medical record.

Questions concerning frequency, volume, number and size should begin with a general statement, such as "How many beers do you drink each day?" Nonspecific answers should always be followed up: "When you say 'a few,' what do you mean? Would you say more or less than six beers a day?" By such a process, the interviewer may gradually have a specific figure as well as some idea of the accuracy and validity of the figure, based on the clarity or haziness of the person's memory and his tendency to minimize or to exaggerate symptoms.

Chronology. The time of onset, duration and frequency and the time course (Does it get better, worse or stay the same with time?) are to be determined. This dimension usually is the one most helpful in organizing and clarifying the patient's symptoms. Questions such as "When was that?," "What happened next?" and "Then what?" not only yield important data at the time but also suggest to the patient that he pay attention to the chronology in the spontaneous account of his story.

Setting. Symptoms develop in relationship to (1) some place—at work, at home, in the patient's car, (2) some activity—eating, arguing, walking; (3) some person—boss, wife, police officer. Understanding these factors can especially help the physician to understand the matrix of the patient's life which influences his disorder and which is in turn influenced by that disorder. The physician is then in a position to take these factors into account in his treatment plans. The initial questions in this area are easily put: "Where were you when it began?" "In what situations do you find yourself getting anxious?" "Was anyone there to help you when it happened?" As the physician has hunches about possible diagnoses, he may ask questions concerning etiological factors. When concerned about the possible cause of liver damage, he may ask whether the person has worked in an area around, or has used, any cleaning compound such as carbon tetrachloride.

Aggravating and Alleviating Factors. Such questions as "Is there anything you can do to relieve your headache?," or "What did you do for it?" or "Is there anything else that helps?" encourage the patient in this area. In two important instances, the patient may withhold information in this area of the history. Patients with problems primarily in the emotional

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area may be self-medicating themselves with alcohol, barbiturates or other harmful drugs to alleviate anxiety or to alter their mood. They are often reluctant to relate this. In the second case, the patient may have tried a remedy which, although not harmful, was embarrassing. This especially applies when the person has used folk remedies or has done something on the advice of a friend, pharmacist or relative, or when the person has used a nonmedical healer (for example, a Mexican-American may have used herbs from a "curandero" but chooses not to relate this out of fear of embarrassment).

As the student physician becomes more adept in recognizing clinical syndromes, certain questions will have additional usefulness in this area. For example, the pain of angina pectoris is characteristically relieved within 1 to 2 minutes by sublingual nitroglycerin. So, if the patient is taking nitroglycerin for any chest pains, information about the speed of relief is important. The questions should be phrased so as not to admit bias or suggest the "right" answer. Rather than, "After you took the nitroglycerin did the pain go away within 2 minutes?" the patient should be asked, "What happened after you took the nitroglycerin?" or "How long was it before the pain subsided?"

Associated Symptoms. It is rare that one symptom appears in isolation. Usually the patient will report other problems, generally less troubling to him, in other organ systems. As the student of medicine becomes more knowledgeable about symptom complexes, he will learn about what to inquire. For example, the patient who is tearful and depressed may often have a poor appetite, weight loss and diminished interest in sex and may awaken in the middle of the night or be constipated.

Instructing the Patient. Questions and instructions should be as simple and as brief as possible. The patient's educational background, intelligence and attitude toward his illness should be taken into account. Nevertheless, even with a well-educated person the physician will generally do better to use the simpler word when two terms are available. Especially, medical terms should be avoided. "Did your skin ever turn yellow?" is preferable to "Did you ever have jaundice?" One reason for this is that the connotation a patient gives a word may be quite different from that which the physician gives it. This suggests two other general guidelines: first, a patient's statement that he had an "ulcer" or a "nervous breakdown" should always be pursued until it is fully clear what symptoms or illness he is actually describing; second, in the area of diagnosis and instruction, the physician should try to establish a common ground of meaning with the patient. What a patient takes the term diabetes or arthritis to mean can only be determined (and then not always) through a candid discussion with him. This is essential, as anxiety or denial concerning a disease state (the adolescent's inability to accept the fact that he is diabetic and the schizophrenic patient's difficulty accepting his illness, based in both cases on the lifelong implications of the disorder and the damage to self-esteem which the "injury" causes) or misconceptions concerning disease (the patient with a renal infection who stops his antibiotics as soon as dysuria abates) are major factors in patients' failures to follow through with treatment. The physician should be explicit in his instructions to the patient. One patient told to drink "a lot" will drown himself while another will drink one glassful between meals. Clarification such as "Drink a total of about 16 ounces every 4 hours" minimizes this response range.

When indicated, make a special effort to explain that the patient should continue to take medication even though he is feeling well. It is difficult for many patients to understand that, in many disorders, there is no relationship between feeling better and no longer needing the drug.

Only one question should be asked at a time. Similarly, the patient should be given instructions one at a time and should have an opportunity to ask questions to clarify any points of confusion. It is useful to have the patient recite the intended treatment regimen. This can be done in a statement such as "Let's see if you're clear about taking this new medicine, Mr. Jones," made with the expectation that he will relate his understanding of the number of pills to be taken at what time of day.

Additional Guidelines. Occasionally, the patient will ramble off the topic. In such cases the physician may interrupt by commenting, "I'm not following that; would you please go back over it?" Persistent inability to adhere to the topic and to relate a coherent story suggests mental retardation, delirium, organic brain syndrome or psychosis.

When questioning the patient in an emotionally charged area, move from factual data into more subjective and emotion-laden areas. For example, in asking a patient with severe angina pectoris about his illness, factual questions about pain should precede questions about functional limitations, which in turn should precede questions concerning the meaning of symptoms to the patient, his fears, hopes, etc. When appropriate, ask questions about the patient's behavior, thoughts and emotions during the physical examination. Questions as wide-ranging as those concerning headaches, visual acuity and auditory hallucinations can often comfortably be asked while examining the head and related organs. This suggestion can be misapplied. It is unlikely that a woman would be most comfortable discussing her sexual life while lying on her back with her feet in stirrups during a pelvic examination.

Information about what is usually called the review of systems can often best be tied into the physical examination. Especially, when by this phase of the examination the physician has a good idea of the range of diagnostic possibilities, he can easily ask questions concerning an organ system while examining that system. This has two additional advantages. It may catch the patient off guard and cause him to relate something of concern which he might not have said during the interview portion. This is a function of the greater implicit authority and accessibility to information which the physician has when laying hands on the patient. Second, the physical examination of the system usually results in the patient's focusing on that system and may cause him to remember important events which he could not have done in the interview portion of the examination.

We have not provided guidelines for the traditional reviews of the system wherein the physician asks a large number of specific questions to obtain encyclopedic data about the patient's past and present conditions. This seems the least useful application of the physician's skills and time. This class of data is better obtained through self-reporting forms or by paraprofessional interviewers. In either case, the physician can then follow up significant positive or negative findings which emerge from this preliminary and increasingly automated area of data collection.

Caveats. Do not ask the patient "why" questions: "Why did you marry your husband?" "Why did your arthritis affect your job?" Such questions are almost invariably poor. They presuppose that the physician is absolutely correct in his assertion, which he may not be. They ask the patient to give a causal explanation when, if he were able to do so, he might not be seeing the physician in the first place. Such a question puts pressure on the patient to agree with the physician. Persons of lower socioeconomic classes often do not think in terms of intrapsychic processes, and such questions are only upsetting to them. Such questions allow the patient to select a plausible answer, which may, however, undermine his appreciating the multiple factors which may have contributed to the difficulty.

Do not argue with, minimize or challenge the patient. It can be easy to lose sight of the truth that your aim is not to prove the rightness of your position but to help the patient. Most persons react negatively, either directly or by responding with the more maladaptive unconscious adaptive mechanisms such as passive aggression, to such an approach. This impasse often occurs when the physician is, in one sense, justifiably angry: The patient has failed to care properly for a wound which the physician had spent time in debriding and suturing, or a mother has not brought her child in for treatment soon enough to make treatment for his rheumatic fever free of danger. But if the patient is aware of his error, he probably already feels guilty enough, and a statement of blame will more likely close off the sense of trust, openness and anxiety-free communication which is a prerequisite to change through the therapeutic relationship. If, on the other hand, the patient was unaware of what he should have done and conflict of motives was not a factor in his behavior, a straightforward educational approach is more likely to be productive.

Specific questions to be avoided, then, are ones such as the following: "Why did you wait so long to bring your boy in, Mother?" (The use of the depersonalized, collective noun "mother" is a stark reminder of the scorn the interviewer feels, in addition to the accusation implied.)

In a similar vein, questions which presume an answer are generally undesirable. "How often do you beat your wife?" presupposes the fact that the person does beat his wife. Only in unusual situations is such an approach justified. An example would be with a patient who is likely to minimize his responses. The physician might well start with the question "How much liquor do you drink?" or "Tell me about your drinking of alcohol," rather than "Do you drink?," which the patient may take as an indecisive gesture which allows him to save face, if he wishes, by saying no and closing off further inquiry.

On the other hand, one should not praise the patient, especially during the first interview. The patient may misinterpret the praise and be falsely reassured. He may not have told the full, embarrassing truth and may find that the praise makes it all the more difficult to be candid in subsequent visits. Or, he may doubt the sincerity of the praise: "If he is this free with his praise when he knows so little about me, how can I be sure of his perceptivity and honesty later on?"

Do not make false reassurances or promises. The patient who asks for such is often laying a trap for the physician: "But you told me it wouldn't hurt." "But you said I would be well within 2 months." The story of the man who asked the physician, who was placing his fractured arm in a cast, whether he would be able to play the violin when the arm healed is a case in point. The physician said, "Why yes, I see no reason why not." To this the patient responded, "That's funny, I couldn't before it was broken." The joke is feeble, but the moral is useful. The meaning of the question to the patient must be understood, as must the knowledge of where the patient is, currently, in regard to the question. To respond to a couple's requests for genetic counseling by telling them that, based on what they have said, you would strongly advise against their having children may not be useful if in fact the girl is already pregnant. The issue of promises in treatment is especially critical with the hypochondriacal person and is discussed at greater length in that chapter.

Do not participate in criticism of the patient's parents, mate, children, friends, associates or other physicians. It is not your task in the treatment relationship to do so. The treating physician is often not at a vantage point to know the multiple sides of the story. He hears only what the patient says, filtered through his personal, protecting biases. A person may feel ambivalent toward those he criticizes and, rather than be pleased with the physician's siding with him, begin to defend the person in question, or feel guilty about his own feelings toward them and either withdraw his trust from the physician or turn his anger toward him. Responses that can be useful are "I see that the situation upsets you very much" or "A remark like that would be disturbing." Unsuitable responses are ones such as "Maybe you were prejudiced against that doctor" or "It's a shame that she doesn't realize what she is doing to you."

Special Techniques

Maintaining the Flow. Often there will be pauses during the interview. At times the patient will have stopped to collect his thoughts or because he is embarrassed or anxious concerning something he has not yet related but knows is important or simply to obtain feedback from the physician that he is on the right track. Often the most useful facilitation is nonverbal. A nod of the head says, "Go on, you are on the right track." Similarly, a rotational movement of the hand encourages the patient to continue. A puzzled or quizzical look with furrowed brow says, "I don't understand, can you elaborate to make that clearer?"

Similar encouragement is conveyed by brief statements such as "yes," "mm-humm" or "go on." A particularly useful, facilitating remark can come after a person has alluded to some issue or problem within the context of discussing another problem or organ system. If the physician allows the patient to continue for several minutes until he has completed a particular explanation, the physician can then come back with a statement such as "A little while back you mentioned that your ulcer flared up after you stopped playing golf—can you tell me more about that?" Not only does the remark ask for a reply, but it also conveys the interest and perceptiveness of the physician.

Confrontation. By confrontation, we mean pointing out to the patient some contradiction between two things that he had said or between his statement and his appearance, or pointing out an emotional response which the patient may either be unaware of or unable to acknowledge. The surgeon who sweeps hurriedly into a room preoperatively and, based on his accurate perception of the patient's appearance, says, "You look scared to death" is practicing a high level skill. Or the physician who says, "You seem awfully sad" may facilitate the person's sharing his sadness, with its tears and meaning, with the physician.

Timing is especially important in the use of confrontation. Confrontation is usually avoided in everyday social interaction, so the physician may feel uncomfortable using it. For certain kinds of situations, timing can be overlooked. When a patient's anxiety is interfering with his responses, it is practically always facilitating to say, "I notice that you are very uncomfortable" or "You appear to be awfully nervous." This acknowledgement often results in an immediate reduction in anxiety, because it suggests that the physician is sensitive and concerned with the way the patient is feeling, and, because the patient may have been attempting to hide his anxiety and finds that he no longer needs to do so, his anxiety lessens. Feelings of anger, especially in depressed persons, should be treated cautiously. The physician may be quite accurate in perceiving a patient's anger or resentment, but to confront him with this often makes him feel more depressed and frightened, as his sense that his anger is unjustified and unacceptable may be one factor in his depression.

Communicating Empathy. The patient often needs and deserves support from his physician. This is especially so following his or the physician's disclosing something of strong emotional content, such as the diagnosis of a terminal illness, or the patient's expressing intense feelings, such as in crying or voicing his fear or despair. Nonverbal means are often useful—a response of silence, clasping a hand of the patient or putting an arm on his shoulder that says, "Yes, I know how hard that must have been for you." Verbally, a comment can be brief: "I know," "I understand"; or longer: "That must have been very upsetting for you" or "This is hard for you." All of these responses cement the solidarity of the relationship, increase the sense of trust and say to the patient that "I will be with you, and available to you, no matter what."

Periods of silence need present no major problems. As suggested earlier, if brief, they may be useful. And in those situations where the patient, overwhelmed with feeling, cries, silence is essential to show that you care about his feelings and that you are not uncomfortable with them. The expression of such feelings is nearly always beneficial, both in immediately relieving tension and in increasing the sense of trust within the relationship.

Family Interviewing. Certain situations invite or necessitate family interviewing, including premarital evaluation, well baby care, acute crisis such as a burn, an evolving crisis such as renal failure and chronic illness such as heart disease and arthritis. Skills in this area will allow the physician to obtain useful information he would not otherwise have and, when appropriate, to utilize the family or a member thereof as a therapeutic tool in his work with the patient. Two common situations are (1) when the family member accompanies the patient and (2) when the family as a unit is interviewed. In the first case, the accompanying person should practically always be interviewed. This person provides a different vantage point regarding the patient's problem. He may be able to corroborate what the patient says or he may allow the physician to observe important interpersonal interaction, such as the patient's efforts to obtain sympathy from the individual or the individual's efforts to scapegoat the patient.

Beyond the initial visit the physician may decide in what context seeing the accompanying person is useful. With the husband of an arthritic woman, full involvement of the man in the interviews will probably be useful. With the mother who accompanies her 20-year-old son for care, it may be better to exclude her from the interview, as her presence implies that her mothering, protective role is still important, a view which is not consistent with the normal emancipation of the adolescent.

In situations where an entire family is interviewed, several additional observational skills need to be utilized. The physician should observe how the family enters the room and who sits next to whom. Who looks to or away from whom? Who speaks, who listens, who smiles, who frowns? Who appeals to, urges, coerces, blames or praises whom? What issues are covered up? About what issues is there apathy, ignorance, confusion or distrust? In short order, dominant interpersonal patterns will be evident and the physician will have learned a great deal about the way in which the family members, individually and collectively, face illness and stress and how they respond to all members within the family.

When interviewing the family as a unit, the physician should seek to transpose conflict and anxiety to the level of active, candid interpersonal exchange. In doing so, the physician should side with healthy adaptation, rather than with a particular family member. He must respect the family's effort to maintain privacy, while encouraging family members to give up pathogenic secretiveness and tacit pacts. This is often seen in families with a member who has a terminal illness. All of the relatives "want to know the truth" but want to "spare Dad, so he can live his time out in happiness." Such an effort to hold in a burden unshared, the anxiety lest one reveal the truth, and the emotional isolation of the ill person invariably make such a tacit pact painful and counterproductive.

Empathy and cooperative solutions to problems among family members should be fostered and any form of scapegoating should be neutralized. Confrontation can be an effective therapeutic tool within the family in a variety of ways. Included are the exposure of maladaptive defenses, the exposure of underlying moods and feelings and confrontation of the family with obvious inconsistencies and contradictions in their beliefs, statements and actions.

Closing the Interview

The physician needs to develop the fine art of appearing not to be hurried. This can be done even while fully acknowledging how busy the physician is likely to be. The open-ended approach to interviewing presented here facilitates the patient's feeling that the physician is intently interested in his problems. Such obvious gestures as fidgeting nervously in the chair, looking at a watch or tapping a finger tell the patient that

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you are either bored or hurried. Verbally interrupting the patient before he has completed a sequence, or saying "mm-hmm" excessively, says the same thing. Many physicians make these errors based on the erroneous belief that such behavior is necessary to get the patient to stop talking. But the physician is in the seat of authority and, when the allotted time is nearly up, he can state matter-of-factly, "Before we stop, Mrs. Jones, I want to summarize what we've gone over today and what our plans are from here. First, I want to know if you have any questions you would like to ask or get cleared up?" He will do well to make clear that the time is up, and not to exceed it by more than a few minutes, unless the situation is emergent or acute.

Occasionally, patients who present no other untoward personality elements in the interview will be tenaciously prone to hold onto the interview and resist its termination. Although this may reflect their characteristic dependency needs, loneliness, a latent depression or fear concerning their illness, it more frequently is symptomatic of a general tendency of the person, once involved in a relationship, to have difficulty giving it up. If the latter is the case, the physician should deal firmly with the patient. As the patient will predictably behave this way on most visits, the physician may find a preventive approach useful. "We only have about 10 more minutes today, and there are a few other things we need to cover before we stop" gives the patient a set time in which to prepare himself emotionally for termination and is considerate, fair and educational for the patient.

If there is a cardinal word about bringing an interview to a close, it is congruence. Evidence is great that failure to understand or agree with the physician's diagnostic impression and treatment plan regarding medications and activities, frequency of visits and length and cost of treatment account for much of the high rate of noncompliance and failure to return for follow-up. Attention to the preceding factors discussed in this section, especially as they bear on moving the patient to the viewpoint and understanding you wish him to have, will materially help in preventing the problem from arising.

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The student of medicine who develops a mastery of the knowledge and skills discussed in this chapter will have the additional benefit of greater comfort in dealing with difficult patients. He will be able to recognize the psychosocial dimensions of the patient's illness—the fact that the patient has a relevant life outside the hospital bed or clinic office. He will have greater skills in working with the family. He will better appreciate the vicissitudes of the doctor-patient relationship and be able to manage it accordingly. He will have the capability to consider the patient as a whole, rather than fragment his problems.

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